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IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

LAMAR ALEXANDER, GOVERNOR OF THE STATE OF TENNESSEE, ET AL.,
Petitioners,

VS.

ROSIER JENNINGS, ET AL.,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTIONS PRESENTED

1. Is a "disparate impact" or "effects" test appropriate to determine a violation of § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and regulations promulgated thereunder?

2. In the alternative, when the Tennessee Medicaid Program provides equal hospital services to the handicapped and nonhandicapped of 14 days per year, per recipient, does such a limit constitute a "disparate impact" or prima facie violation of § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and regulations promulgated thereunder when the limit will satisfy all needed hospital care for 95% of the eligible handicapped recipients?

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Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

The Petitioners, Lamar Alexander, Governor of the State of Tennessee, et al., respectfully request that a Writ of Certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Sixth Circuit entered in this proceeding on August 4, 1983.

OPINIONS BELOW

The opinion of the Court of Appeals (reprinted in the Appendix at A.1) is reported at____F.2d____(6th Cir. 1982) (dissenting opinion). The opinion of the Court of Appeals reviews the District Court opinion (reprinted in the Appendix at A. 27) which is reported at 518 F.Supp. 877 (D.C. Tenn., M.D. 1981).

JURISDICTION

The Judgment of the Court of Appeals for the Sixth Circuit was entered on August 4, 1983 and this Petition for Certiorari was filed within ninety (90) days of that date. This Court's jurisdiction is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

Section 504 of the Rehabilitation Act of 1973, as amended, and codified at 29 U.S.C. § 794 provides:

> No otherwise qualified handicapped individual in the United States, as defined in section 706(7) of this title, shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service. The head of each such agency shall promulgate such regulations as may be necessary to carry out the amendments to this section made by the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act of 1978. Copies of any proposed regualtion shall be submitted to appropriate authorizing committees of the Congress, and such regulation may take effect no earlier than the thirtieth day after the date on which such regulation is so submitted to such committees.

FEDERAL REGULATIONS INVOLVED

45 C.F.R. §§ 84.1-5 of the rules and regulations promulgated by the Secretary of Health and Human Services are set forth in the Appendix at A. 52.

STATEMENT OF THE CASE

This case involves the legality of a decision by the Tennessee Medicaid Program to reduce the number of inpatient hospital days the program provides in a fiscal year to each elegible recipient from 20 to 14.[1] At issue is whether or not this reduction violates § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) (hereinafter § 504) and regulations promulgated thereunder. The reduction was scheduled to go into effect on August 15, 1980, along with other program reductions to ensure the continued existence of the financially strapped Medicaid program. The Respondents, Plaintiffs below, all Tennessee Medicaid recipients, filed suit on August 14, 1980 to enjoin these proposed changes.[2] Named as Defendants, Petitioners in this Court, were the Governor of Tennessee and three (3) other State officials responsible for administration of the Medicaid program.

With respect to the reduction in inpatient hospital days, the Respondents argued, *inter alia,* that the reduction violated § 504 in that it effected the handicapped more adversely than the nonhandicapped. Evidence presented at trial, which commenced on February 17, 1981, established that during the preceeding fiscal year of 1979-80, there were 341,960 persons eligible to receive Medicaid services in Tennessee. Of this number, 90,668 were classified as handicapped and 16,852 of them used one or more hospital days. Of the remaining 250,332 nonhandicapped

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[1] The Tennessee Medicaid Program is a joint state and federal program providing comprehensive medical care for indigents. 42 U.S.C. §§ 1396a, *et seq.* and Tennessee Code Annotated §§ 14-23-101 *et seq.*

[2] The District Court predicated subject matter jurisdiction on 28 U.S.C. §§ 1331 and 1343, *Hagans* v. *Lavine,* 415 U.S. 528, 94 S.Ct. 1372, 39 L.Ed.2d 577 (1974) and *Bell* v. *Hood,* 327 U.S. 678, 66 S.Ct. 773, 90 L.Ed.939 (1946).

recipients, 34,288 were in the hospital for one or more days during the study year. *See, Jennings* v. *Alexander,* 518 F.Supp. 877, 880 (D.C.Tenn.M.D. 1981); A. 31-32. Studies were prepared by the Medicaid program to determine what would have been the effect of a 14-day limitation had it been in place during fiscal year 1979-80. The District Court accurately described the result of the studies:

> [The evidence]. . . showed that for the fiscal year examined, 72.6% of the handicapped users would have been fully served by 14 days of hospital inpatient coverage. Stated otherwise, 27.4% of all handicapped users in 1979-80 needed more than 14 days of inpatient hospital treatment. By contrast, 92.2% of all nonhandicapped users were fully served at 14 days or less, leaving only 7.8% in need of inpatient hosptial care beyond the 14th day. *Id.* at 881; A. 32.

The District Court, in making its own calculations, also found as follows:

> Indeed, the actual impact of the proposed limitation, even in the study year, should be kept in perspective. Since only 18.586% of handicapped eligibles used any inpatient hospital services, and 27.4% of those needed more than 14 days, only about 5% of the handicapped eligibles were in need of more than 14 days of hospital treatment. Thus, 95% would have been fully served at 14 days. *Id.* at 882, n.6; A. 32.

The District Court properly concluded that the proposed reduction in the number of inpatient hospital days did not violate § 504. While agreeing that a "disparate impact" test was appropriate, the Court found that the alleged adverse effect of the reduction on the handicapped simply did not rise to the level of a "disparate impact." *Id.* at 885; A. 40. In so ruling, the Court held that § 504 was never intended to ensure equality of

results but only equal access by the handicapped to programs such as Medicaid. *Id.* A. 42-43. The Court carefully distinguished the present case from those cases where the alleged "disparate impact" amounted to an outright exclusion of the handicapped from the service or benefit in question. *Id.* at 883-884; A. 36-40.

On appeal, a three-judge panel of the Sixth Circuit Court of Appeals, Judge Merritt dissenting, reversed the District Court ruling and remanded the case to the District Court for further proceedings. *Jennings* v. *Alexander,* ____ F.2d ____, (6th Cir. 1983); A.1. The Court of Appeals agreed with the District Court that a "disparate impact" test was appropriate for determining a violation of § 504. In general, this test allows a plaintiff to establish a "prima facie" case if he can show that an activity covered under § 504, though facially neutral, has a "disparate impact" upon the handicapped as opposed to the nonhandicapped. If a "disparate impact" is made out, then the burden shifts to the defendant to justify the disparity of treatment as necessary to achieve a legitimate goal of the activity under scrutiny.

The Court of Appeals, contrary to the District Court, found that the 20 to 14-day reduction, based on the data in the record, constituted a "disparate impact" upon the handicapped. The Court of Appeals found a "disparate impact" solely on the fact that 92.2% of all nonhandicapped who needed hospital care would have all their needs met at a 14-day limit as opposed to 72.6% for the handicapped. Under the Court of Appeals reasoning, there would be a "disparate impact" until these two (2) percentages were equal. Anything short of this equanimity would constitute a prima facie violation of § 504. Accordingly, the Court of Appeals reversed the District Court and remanded the case for further proceedings to determine if the Defendant Medicaid officials could rebut the prima facie violation of § 504.

Judge Merritt, in a vigorous dissenting opinion, found no "disparate impact" in the fact that "some" handicapped will be more adversely effected than the nonhandicapped. *Id.* at____; A. 21. He saw the majority opinion as having turned the "disparate impact" test under § 504 into a results test requiring federally funded programs and services to be equally efficacious in their results to the handicapped and nonhandicapped alike. *Id.* at____; A. 22. Judge Merritt concluded that the majority's ruling created a whole new and unnecessary source of challenges to the state's budgetary process:

> Without a clear, bright line distinction based on access, like the District Court makes, the Court's decision will create a whole new source of challenges to the state budgetary decisions. People with physical ailments depend on a myriad of state services more heavily than do people with no ailments. When a local government decides to reduce the quality, frequency or financing for some service, for example, bus service, some group could make a case of discrimination, for example, by showing that they use the buses more than others. Across-the-board cuts in welfare, social security, education and many other benefits will affect some groups more than others and will open the way to litigation. I do not believe that Congress intended this statute to authorized the federal courts to step in and control the state budgetary process when cuts in appropriations affect asthmatics, or some other class of patients, somewhat more heavily than another group of patients. *Id.* at____; A. 21-22.

Judge Merritt was also of the opinion that no "disparate impact" or "effects" test was appropriate under § 504. *Id.* at ____; A. 25.

REASONS FOR GRANTING WRIT

I.

This Court Needs To Correct An Erroneous And Unprecedented Ruling Of The Court Of Appeals Which Seriously Impedes The Ability Of The Tennessee Medicaid Program And Other Entities Subject To Section 504 To Efficiently And Economically Administer Federally Funded Programs Effecting Handicapped Persons.

The issues presented by this petition are significant and potentially far reaching. In adopting a "disparate impact" or "effects" test to determine whether or not the Tennessee Medicaid Program violated § 504, the Court of Appeals established a standard applicable to all programs, services or activities covered under § 504. This includes all federally funded health care services, educational programs or transportation services. Furthermore, it could be argued that this standard applies to Title VI (42 U.S.C. § 200d) cases as well. The Sixth Circuit followed closely the rationale of *N.A.A.C.P.* v. *The Medical Center, Inc,* 657 F.2d 1322 (3rd Cir. 1981) (*en banc*) which saw no fundamental distinction between a § 504 and Title VI analysis and applied the same "disparate impact" test to both.

The threshold question presented in this case is whether or not a "disparate impact" or "effects" test utilized by the Sixth Circuit is appropriate to determine a violation of § 504 and regulations promulgated thereunder. This Court has never addressed the question. It did, however, recently deal with the propriety of an "impact" or "effects" test in the context of alleged racial discrimination under Title VI in *Guardians Association* v. *Civil Service Commission of New York,* 51 U.S.L.W. 5105 (decided July 1, 1983). A majority of the Court in *Guardians* held that to sustain an award of compensatory damages under Title VI, disciminatory "intent" as opposed to "effect" must be demonstrated. The Court remained divided, however, on the

precise question of the propriety of an "impact" or "effects" test to establish a violation of Title VI. The petitioners respectfully submit, for reasons expressed by the several justices of this Court in *Guardians,* that an "impact" or "effects" test is equally inappropriate within the context of alleged handicapped discrimination under § 504. Indeed, due to the inherent differences between § 504 and Title VI, there is less justification for an "impact" or "effects" test under § 504. Therefore, the question should be addressed in a §504 context.

In the alternative, if an "impact" or "effects" test is appropriate, there is simply no basis in fact or law to warrant the Court of Appeals' standard for what constitutes a "disparate impact". First, the Court of Appeals ignored the fact that all eligible Medicaid recipients, *handicapped and nonhandicapped alike,* would be provided 14 inpatient hospital days per fiscal year. There was no evidence that the limit would render inpatient hospital benefits a nullity to the handicapped. On the contrary, the evidence showed that a 14-day limit would provide all the needed hospital days for 72.6% of all the handicapped who needed hospital care in a given year. As computed by the District Court, this amounted to satisfying all the hospital needs of 95% of the eligible handicapped Medicaid recipients.

Second, the Court of Appeals' standard is also at odds with the plain meaning of § 504 and regulations promulgated thereunder. Section 504 simply prohibits federally funded programs or activities from excluding, denying or discriminating against handicapped individuals on the basis of a handicapping condition. 29 U.S.C. § 794. No where is equality of results mandated. To the contrary, regulations promulgated by the Secretary of Health and Human Services, applicable to the Tennessee Medicaid Program, specifically interpret § 504 as **not** requiring a federally funded program to ". . . produce the identical result or level of achievement but only an equal opportunity to obtain the same results." 45 C.F.R. § 84.4(b)(2). A. 56.

Third, the standard adopted by the Sixth Circuit is inconsistent with this Court's narrow application of § 504 and similar laws. In *Southeast Community College* v. *Davis,* 442 U.S. 397, 410-411, 99 S.Ct. 2361, 2369, 60 L.Ed.2d 980, 991 (1979) this Court recognized in § 504 ". . . [a] distinction between evenhanded treatment of qualified handicapped persons", which is required, and "affirmative action" to overcome the disabilities caused by handicaps, which is not required. *See, also, Board of Education of the Hendrick Hudson Central School District* v. *Rowley,* ____U.S.____, 102 S.Ct. 3034, 73 L.Ed.2d 690 (1982) for a similar interpretation under the Education for the Handicapped Act, 20 U.S.C. § 1412(1). The unwillingness of this Court to liberally construe § 504 is reflected in the recent case of *Community Television of Southern California* v. *Gottfried,* ____U.S.____, 1035 S.Ct. 885, 74 L.Ed.2d 705 (1983) where it was held that § 504 did not require the Federal Communications Commission in the normal course of its business to scrutinize a public television station for violations of § 504.

Furthermore, the petitioners know of no other Circuit which has adopted the erroneous "disparate impact" standard which is now the law in the Sixth Circuit. The other Circuits have only applied a "disparate impact" test under Title VI or § 504 to situations where the handicapped were excluded or denied access to certain covered benefits. This is true even in the cases relied upon by the Sixth Circuit. *N.A.A.C.P.* v. *Medical Center, Inc.,* 657 F.2d 1322 (3rd Cir. 1981) and *Bryan* v. *Koch,* 627 F.2d 612 (2nd Cir. 1980) (denial of access to handicapped and minorities by public hospitals); *Prewitt* v. *United States Postal Service,* 662 F.2d 292 (5th Cir. Unit A. 1981), (denial of access to equal employment opportunities).

Finally, the broad "disparate impact" standard established by the Court of Appeals will invite litigants to embroil the states and other entities in protracted litigation over alternative means of fine tuning federally funded programs and services to achieve

equality of results when in fact the policy determinations for these decisions should be decided by elected public officials.

CONCLUSION

For the reasons set forth above, the petitioners respectfully request that a Writ of Certiorari issue to review the judgment and opinion of the Fifth Circuit to determine the appropriateness of a "disparate impact" or "effects" test under §504 or in the alternative the propriety of the "disparate impact" standard adopted by the Sixth Circuit in this case.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing Petition has been mailed this the 31st day of October, 1983, to the below-referenced counsel.

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No. 81-5629

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

Rosier Jennings b/n/f; Kathleen Jennings; Hershel Choate; Wilma Ann Hyder; Clyde Vaughn b/n/f; Edith Vaughn; Paul Ramone Parsons b/n/f; Lou Ann Bradley; Rebecca West b/n/f; Paulette West; Michaelle Ogle b/n/f; Lind Sue Ogle; Eldon Kerr; Stella Karris; Sadie I. Owens; Margaret Betty; Charles Baldwin; Carrie Clemons,

Plaintiffs-Appellants,

v.

Lamar Alexander; Eugene Fowinkle; Ben Crim; Carolyn Hale,

Defendants-Appellees.

On Appeal from the United States District Court for the Middle District of Tenessee.

Decided and Filed August 4, 1983

Before: Keith, Merritt, and Jones, Circuit Judges.

Keith, Circuit Judge, delivered the opinion of the Court, in which Jones, Circuit Judge, joined. Merritt, Circuit Judge, (pp. 20-26) filed a separate dissenting opinion.

Keith, Circuit Judge. Appellants, Medicaid recipients from the State of Tennessee, challenge the State's attempt to restructure its Medicaid Plan. Appellants contend that Tennessee's

proposed reduction in the number of hospital days covered by Medicaid from twenty to fourteen per annum violates Section 504 of the Rehabilitation Act, 29 U.S.C. §794 and Section 1396(a)(19) of the Medicaid Act, 42 U.S.C. §1396a(a)(19). They also argue that any reduction must be approved by the Secretary of Health and Human Services. After a bench trial, the district court dismissed each of Appellants' claims. For the reasons set forth below, we vacate the district court's order and remand this case for further consideration not inconsistent with this opinion.

This action was originally brought in the United States District Court for the Middle District of Tennessee on behalf of all the State's Medicaid recipients. It challenged an array of proposed reductions by the State designed to save money on the State's share of Medicaid expenditures.[1] The proposed reductions included, *inter alia,* deletion of certain drugs from the Medicaid formulary, reductions in the level of reimbursement for health care providers, reduction of inpatient hospitalization coverage, and reduction of outpatient hospitalization services. Appellants also sought to enjoin the proposed reductions because they had not been approved by a valid Medicaid Medical Care Advisory Committee as prescribed by federal regulations. 42 C.F.R. §431.12.

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[1] Medicaid is a voluntary undertaking by a state. The Federal government places no ceiling on funds to a state program, but federal funds are contingent upon matching funds by the state. Although the program is voluntary, once a state decides to participate, it must do so in conformity with the requirements of Title XIX of the Social Security Act of 1965 and applicable regulations. *Harris* v. *McRae,* 448 U.S. 297, 301 (1980).

The State of Tennessee provides approximately thirty state dollars for each seventy dollars the federal government contributes. For fiscal year 1980-81, the Tennessee General Assembly "appropriated state dollars which, when matched with federal funds, constituted a budget of $388,000,000." This figure represented a $26,000,000 increase over the State's Medicaid budget for the preceding year.

On September 3, 1980, the district court enjoined the State's promulgation of the proposed reductions until a validly constituted Medical Care Advisory Committee had reviewed them. On December 12, 1980, the State petitioned the district court to set aside the preliminary injunction. The State argued that a properly constituted committee had not acted after having sufficient time to do so. The court did not rule on this motion.

By the time of the March 13, 1981 bench trial, the validity of only two proposed reductions were at issue: the deletion of certain drugs from the Medicaid formulary and the reduction in the number of inpatient days for which Medicaid would pay. Prior to the district court's opinion on June 17, 1981, the parties settled the former issue. Only the validity of the State's reduction in hospitalization coverage remained to be resolved by the court.

In its opinion, the district court held (1) that the proposed reduction did not violate Section 504 of the Rehabilitation Act of 1973, (2) that the proposed reduction was not inconsistent with the best interests of the recipients in contravention of 42 U.S.C. §1396(a)(19), and (3) approval from the Secretary of Health and Human Services was not needed to implement the changes. However, the court found that the State had failed to comply with the procedures outlined in 42 C.F.R. § 447.205 which establish guidelines for providing public notice of proposed changes. Therefore, the court refused to set aside its September 3, 1980 preliminary injunction.

I.

The initial question for review is whether the district court erred in holding that the proposed reduction from twenty to fourteen days per annum does not violate Section 504. The district court held that the appellants had not made a showing of discrimination against the handicapped becasue there had been no showing of disparate impact upon handicapped persons. Furthermore, the court held that even if Appellants had

proved disparate impact, the disparate impact was not discrimination against the handicapped as contemplated by the Rehabilitation Act of 1973. We disagree.

A.

29 U.S.C. §794 provides in relevant part:

> No otherwise qualified handicapped individual in the United States, as defined in section 706(7) of this title, shall, solely by reason of of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.[2]

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[2] Handicapped individual as defined at 29 U.S.C. 706(7):

(7) (A) Except as otherwise provided in subparagraph (B), the term "handicapped individual" means any individual who (i) has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment and (ii) can erasonably be expected to benefit in terms of employability from vocational rehabilitation services provided pursuant to subchapters I and III of this chapter.

(B) Subject to the second sentence of this subparagraph, the term "handicapped individual" means, for purposes of subchapters IV and V of this chapter, any person who (i) has a physical or mental impairment which substantially limits one or more of such persons's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment. For purposes of sections 793 and 794 of this title as such sections relate to employment, such term does not include any individual who is an alcoholic or drug abuser whose current use of alcohol or drugs prevents such individual from performing the duties of the job in question or whose employment, by reason of such current alcohol or drug abuse, would constitute a direct threat to property or the safety of others.

The courts which have considered the issue have uniformly held that Section 504 creates a private cause of action for those who are its intended beneficiaries. *See infra* note 4 and accompanying text. Although the Supreme Court did not address this issue in *Southeastern Community College* v. *Davis*, 442 U.S. 397 (1981), its actions in several cases suggest that the Court has assumed that a private cuase of action exists in Section 504 cases. *ID.*[3].

Though a thorough examination of this issue has already been provided by several circuit courts, we note our agreement that sound judicial analysis supports implying a private cause of action for injunctive relief. In its discussion of the Technical and Clarifying Amendments to the Rehabilitation Act, the Senate Report explained:

> Section 504 was patterned after and is almost identical to, the antidiscrimination language of section 601 of the Civil Rights Act of 1964, 42 U.S.C. 2000d-1 (relating to race, color, or national origin) and section 901 of the Education Amendments of 1972, 42 U.S.C. 1683 (relating to sex). The section therefore constitutes the establishment of a broad government policy that programs receiving Federal financial assistance shall be operated without discrimination on the basis of handicap. It does not

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For purposes of this case, statistics relating to handicapped recipients include "only those recipients whose Medicaid eligibility is based on blindness or disability." All recipients over sixty-five (65) are classified as aged whether or not they are blind or disabled. Furthermore, "[o]f those recipients of inpatient services who have only Medicaid (no Medicare) coverage, 1,833 are 'aged.'" Since the parties could not agree on how many of these recipients were handicapped, they are all reflected in the statistics as non-handicapped.

[3]. *See, e.g., Campbell* v. *Kruse*, 434 U.S. 808 (1977), where the Supreme Court vacated the district court's order and remanded the case for a decision based on Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794.

specifically require the issuance of regulations or expressly provide for enforcement procedures, but it is clearly mandatory in form, and such regulations and enforcement are intended.

The language of Section 504, in following the above-cited Acts, further envisions the implementation of a compliance program which is similar to those Acts, including promulgation of regulations providing for investigation and review of recipients of Federal financial assistance, attempts to bring non-complying recipients into voluntary compliance through informal efforts such as negotiation, and the imposition of sanctions against recipients who continue to discriminate against otherwise qualified handicapped persons on the basis of handicap. Such sanctions would include, where appropriate, the termination of Federal financial assistance to the recipient or other means otherwise authorized by law. Implementation of section 504 would also include pregrant analysis of recipients to ensure that Federal funds are not initially provided to those who discriminate against handicapped individuals. Such analysis would include pre-grant review procedures and a requirement for assurances of compliance with section 504. This approach to implementation of section 504, which closely follows the models of the above-cited anti-discrimination provsions, would ensure administrative due process (right to hearing, right to review), provide for administrative consistency within the Federal government as well as relative ease of implementation, and permit a judicial remedy through a private.

S. Rep. No. 1297, 93d Cong., 2d Sess. 6390-91, *reprinted in* 1974 U.S. Code Cong. & Ad. News 6373.

The guidelines enunciated in *Cort v. Ash*, 422 U.S. 66 (1975) for implying a private cause for action are clearly met. First, Section 504 was enacted for the special benefit of handicapped

persons as defined in the Rehabilitation Act. Second, there is express language in the legislative history which supports a congressional intent to imply a private cause of action. Third, the structure and underlying purpose of the Act is consistent with the implication of a private judicial remedy. Finally, the cause of action is not one generally relegated to the states and inappropriate for federal law. We, therefore, agree with the other circuits that have considered the issue and hold that Section 504 creates a private cause of action for its intended beneficiaries.[4]

B.

Section 504 is "part of the general corpus of discrimination law." *New York State Association for Retarded Children* v. *Carey*, 612 F.2d 644 (2d Cir. 1979). It is predicated on Title VI of the Civil Rights Act, 42 U.S.C. §2000d, and is intended to prohibit the expenditure of public funds in programs that discriminate against the handicapped. *See* Sen. Rep. 1297, *supra*. Courts have generally applied the same tests of discrimination law to Section 504 as are applied to Title VI.

In *N.A.A.C.P.* v. *The Medical Center, Inc.*, 657 F.2d 1322 (3d Cir. 1981), (*en banc*), the Third Circuit exhaustively considered the evidence needed to prove a prima facie violation of Title VI. Having concluded that Title VI requires only that a

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[4] *See Leary* v. *Crapsey*, 566 F.2d 863 (2d Cir. 1977) *(per Curiam); N.A.A.C.P.* v. *The Medical Center, Inc.*, 599 F.2d 1247 (3d Cir. 1979), *aff'd.*, 657 F.2d 1322 (3d Cir. 1981) (*en banc*); *Davis* v. *Southeastern Community College*, 574 F.2d 1158 (4th Cir. 1978), *rev'd on other grounds*, 442 U.S. 397 (1979); *Camenisch* v. *University of Texas*, 616 F.2d 127 (5th Cir. 1980), *cert. granted*, 449 U.S. 950, *vacated*. 451 U.S. 390 (1981); *Lloyd* v. *Regional Transportation Authority*, 548 F.2d 1277 (7th Cir. 1977); *United Handicapped Federation* v. *Andre*, 558 F.2d 413 (8th Cir. 1977); *Kling* v. *County of Los Angeles*, 633 F.2d 876 (9th Cir. 1980); *Puskin* v. *Regents of the University of Colorado*, 658 F.2d 1372 (10th Cir. 1981); *Prewitt* v. *United States Postal Service*, 662 F.2d 292 (11th Cir. 1981) (former Fifth Circuit opinion).

plaintiff prove disparate impact in the application of federal funds, the court concluded, "The Rehabilitation Act and the Age Discrimination Act of 1975 provide equally strong cases for application of an impact test since both are patterned after Title VI." *ID.* at 1331. *See also Bryan* v. *Koch,* 627 F.2d 612, 621 (2d Cir. 1980).

Both *Bryan* and *The Medical Center* involved the use of federal funds by a state or municipal government to implement a facially neutral policy which affected certain protected groups more harshly than others. As Judge Kearse noted in *Bryan,* the regulatory agencies responsible for effectuating Title VI-type statutes have applied "a broad 'disparate impact,' or 'effects,' test." (Separate Opinion of Judge Kearse at 621). Indeed, the regulations promulgated under Section 504 specifically forbid the use of federal funds for programs which have discriminatory effects against the handicapped.[3] Regulations by the enforcing agency are entitled to great weight. *Brennan* v. *Owensboro-Davies County Hospital,* 523 F.2d 1013, 1028 (6th Cir. 1975), *cert. denied,* 425 U.S. 973 (1976).

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[3] 45 C.F.R. 84.4 (1981) provides in relevant part:

> §84.4 Discrimination prohibited.
>
> (a) General. No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.
>
> • • •
>
> (4) A recipient may not, directly or through contractual or other arrangements, utilize criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect to handicapped persons, or (iii) that perpetuate the discrimination of another recipient if both recipients are subject to common administrative control or are agencies of the same State.

The district court acknowledged authority for applying an effects test in this case. It then proceeded to distinguish cases applying on effects test, most notably the district court opinion in *The Medical Center.*[4] The district court concluded that *The Medical Center* was not applicable. We disagree.

The factual distinction between this case and *The Medical Center* is not analytically significant for purposes of determining what constitutes a prima facie case. *The Medical Center* involved the relocation of a hospital from an inner-city location to a suburban site. This was challenged as having an adverse effect upon minorities and the aged as well as the handicapped. The district court concluded that an effects test should be applied. After extensive litigation, the Third Circuit, sitting *en banc,* affirmed the application of an adverse effects test, but found that the plaintiff had not produced enough evidence to prove a prima facie case. *See also Prewitt v. United States Postal Service,* 662 F.2d 292 (5th Cir. 1981) (application of a discriminatory impact test when federal government is the employer in handicapped discrimination case); *Bryan* v. *Koch,* 627 F.2d 612 (2d Cir. 1980) (expressing no view on issue, the court assumed disparate impact test to be appropriate but found city had met its burden of rebuttal).

We think the district court erred by confusing the prima facie case with a decision on the ultimate outcome. The district court, seeking to minimize the importance of the *The Medical Center* district court, opined:

> Thus, it is far from clear that the *The Medical Center* court intended to adopt as strict an "impact test" as the plaintiffs contend. Rather, it would appear that the court recognized that a program need not be equally productive

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[4] The district court opinion in this case was rendered before the Third Circuit's panel and *en banc* opinions in *N.A.A.C.P.* v. *The Medical Center.*

> for handicapped and non-handicapped alike, as long as the program is equally accessible to both groups.

518 F.Supp. 877 (M.D. Tenn. 1981). But the appellate opinions in *The Medical Center* hold that the establishment of a prima facie case is merely a prelude to the court's assessment of whether the alternative chosen is discriminatory against the handicapped. The establishment of disparate imapct is not determinative of whether the defendant is guilty of discrimination. It merely requires the defendant to rebut the inference of discriminatory action. We therefore hold that the showing of disparate impact proved a prima facie case and required the state to explain its choice.

C.

Alternatively, the district court held that even if discriminatory impact had been shown, the plaintiffs had failed to prove a prima facie case. The court reasoned:

> For example, there was no attempt to show what percentage of handicapped users required inpatient hospital treatment as a result of their handicapping condition. It seems likely that some handicaps, such as blindness, would rarely require hospitalization, while others, such as mental illness, might well require frequent hospitalization. Without some such evidence, the court is left to speculate on what extent the existence of handicaps in the broad sense of §504 affects the statistical disparity shown for the study year. Indeed, the actual impact of the proposed limitation, even in the study year, should be kept in perspective. Since only 18.586% of handicapped eligibles used any inpatient hospital services, and 27.4% of those needed more than 14 days of hospital treatment. Thus, 95% would have been fully served at 14 days.

518 F.Supp. at 883 n.6. Again, we disagree. We agree with the district court that the statistical evidence was not perfect. But

we also note that since a significant number of Medicaid recipients have been omitted from the statistics, it is much more likely that the numbers understate the disparity between handicapped and non-handicapped Medicaid users.[7]

Furthermore, the district court's statement that no evidence was presented which would suggest that the disparity would continue is clearly erroneous. Along with their statistical evidence, the plaintiffs presented medical testimony which described the inpatient hospitalization pattern of patients with certain handicaps. For example, Dr. Samuel Marney, who specializes in the treatment of pulmonary ailments, testified upon deposition that patients suffering from asthma, emphysema, chronic bronchitis, or other obstructive lung diseases often "require longer hospitalization for intensive therapy than fourteen days." Dr. Georgia Montouris, a neurologist, testified upon deposition that, "Degenerative diseases of neurology often require hospitalizations." She further testified that fourteen days a year would not adequately take care of such patients' needs. Dr. Joseph Stinson stated in his deposition that in his experience the average asthma patient requires hospitalization four to five times a year with an average stay of ten to fourteen days. Dr. Gordon Turner, a surgeon, testified upon deposition that limitations on the number of days rather than number of admissions often caused handicapped persons to delay surgery until minor surgery became major surgery.

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[7] *See supra* note 2. We also note that the State concedes that its proposed reductions have a disparate impact on the handicapped. The State's appellate brief admits:

> The statistics and studies were compted and analyzed by the parties in several different ways during the course of the trial. Suffice it to say, the studies indicated that the handicapped population of Medicaid recipients would suffer proportionally more from the reduction in hospital benefits than the non-handicapped Medicaid recipients.

Even if we were not persuaded by the bare statistical evidence, the opinions of these medical experts along with other expert testimony wuld convince us that the plaintiffs presented a prima facie violation of Section 504. The medical evidence buttresses the position that these statistics are probative of discrimination against the handicapped.[8]

D.

Having found a prima facie violation of Section 504, we now find it appropriate to consider the justification offered by the State for adopting the fourteen day inpatient maximum. We consider this justification along with the plaintiff's contention that an alternative was available which would save the State the same amount of money and have a less discriminatory effect on the handicapped.

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[8] The dissenting opinion argues that this case is more analogous to *Doe* v. *Colautti*, 592 F.2d 704 (3d Cir. 1979) and other cases which discuss physical access to facilities. The dissent appears to agree with the district court that "physical access" is all that section 504 requires. Yet such a wooden notion of access is clearly not what was intended by the enactment of section 504. Rather, "access" must be read in terms of the goals fo the Act. 45 C.F.R. §84.4(b)(2) requires that the handicapped be given an equal opportunity to succeed at the goal of the program. Further, 45 C.F.R. §84.4(b)(4) states that the program must be run in a manner that does not impair the objectives of the plan. Though not every inequality in the number of days provided to handicapped and non-handicapped persons constitutes discrimination against the handicapped, it certainly would be too simplistic an analysis to hold that all the Medicaid program requires is a particular number of days in the hospital. Rather, it is likely that the objective is to afford the best cure, therapy, or preventative treatment that the allotted funds can provide. This is made clear by the Tennessee law defining medical assistance as the "payment of the cost of care, services and supplies necessary to prevent, diagnose, correct or cure conditions in the person." Tenn. Code Ann. §14-23.103(2). The disparate impact shown here, we conclude, shows the kind of inequality sought to be prevented by section 504.

We begin our analysis with an acknowledgement that the State has a great deal of latitude in structuring the services it provides to its citizens. But it may not use federal funds in a program which discriminates against a racial group (Title VI), a particular sex (Title IX), or individuals with handicaps (Section 504). Moreover, we agree with the court's opinion in *New York State Association For Retarded Children v. Carey* at 650:

> Requiring governmental agencies to rebut in court a prima facie case of discrimination against the handicapped does not mean that the expertise of responsible administrators is to be denigrated. When the validity of challenged governmental action turns on an assessment of technical matters foreign to the experience of most courts, it may be entirely appropriate to resolve closely contested disputes in favor of the responsible administrators.

The State clearly proved that is was justified in attempting to reduce its Medicaid expenses. "No one would contest that the [State] must assign priorities among competing economic demands and evaluate political and economic alternatives. *Bryan* at 621 (Separate Opinion of Judge Kearse). The evidence presented showed that the Medicaid program would have required $42,000,000 additional dollars to maintain the same level of services during fiscal year 1980-81 as were provided in fiscal year 1979-80. Since the State of Tennessee is prohibited by statute from deficit spending in its Medicaid program, it must provide services within the means granted by its General Assembly. The plaintiffs do not dispute this, and this court accepts these parameters.

But the plaintiffs contend that the State could achieve the same level of savings by an alternative method. They argue that the State could achieve the desired level of savings by limiting the total number of visits per annum rather than the number of days. According to plaintiffs, this alternative is preferable because the handicapped would not be deterred from going to

the hospital earlier. Thus, the illness could be diagnosed and treated at an earlier stage, decreasing the need for long periods of hospitalization. Moreover, testimony was presented that, in individual cases, hospitals are not likely to eject Medicaid patients who exhaust their Medicaid days while in the hospital. But many hospitals will refuse entrance to sick persons who have no Medicaid days left. Dr. Marney, Dr. Turner, and Dr. Stein all indicated in their testimony that it would be better for the patients to have a system where they could come to the hospital on numerous occasions than to have a fixed number of days.

On the other hand, the State produced no evidence to rebut the plaintiff's claim. Rather, the evidence indicated that the State only considered two alternatives. The first was a change in the reimbursement method for health care providers. This was hastily withdrawn when the providers protested and it was learned that such a change would require approval from the Department of Health, Education and Welfare. A reduction in the services provided to Medicaid patients was instituted in its place. The testimony of Mr. James E. Word, Deputy Commissioner of Public Health, indicated that no attention was given to the discriminatory impact this might have on the handicapped or any group.

Federal courts are not empowered to substitute their judgments for that of State officials charged with administrative fact finding and decision making have to do with the state. *New York State Association for Retarded Children* v. *Carey,* 612 F.2d at 648; *Bryan* v. *Koch,* 627 F. 2d at 619; *The Medical Center,* 657 F.2d at 1338.

> However, the courts are...assigned a sensitive task, and that task is to ensure that the established legal standards — constitutional and statutory — are followed by government agencies. To permit the factual determinations of these agencies to go unchallenged may be to neglect this task, for the facts will often be dispositive, and the ques-

> tion of compliance with legal standards will often be determined by the manner in which the agency has found the facts.

Carey, F.2d at 648.

In this case, the plaintiffs proved a prima facie case of discrimination against the handicapped *and* purported to present an alternative which had a less discriminatory impact and would meet the State's need to save money. When a recipient of federal funds uses the money in a manner which has disparate impact, Section 504 requires, at the least, that the State show that its decision-making process was a rational one. *Bryan* v. *Koch,* 627 F.2d at 621 (Separate Opinion of Judge Kearse) (in the context of Title VI and racial discrimination).

This is not an onerous burden. It merely requires the recipient to present some evidence that its decision is the product of lawful process which complies with minimum statutory standards. Courts are not free to ignore claims of discrimination merely because they are against a state. As the Second Circuit has noted:

> Clearly, deference to a state agency's fact finding is inappropriate once that agency is the defendant in a discrimination suit. The agency is required to come forward in the district court with sufficient evidence to rebut the plaintiff's *prima facie* case (footnote omitted).

Carey, 612 F.2d at 649.[9]

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[9] Our antidiscrimination analysis is similar to that employed in *N.A.A.C.P.* v. *The Medical Center, Inc.,* 657 F.2d 1322 (3d Cir. 1981) (*en banc*) and *Bryan* v. *Koch* 627 F.2d 612 (2d Cir. 1980). In *Wilmington Medical Center,* the court found that the defendant had justified its decision to relocate an inner city hospital to a suburban site although the relocation adversely affected certain protected groups. The court affirmed the district court which required the defendant to prove that it had chosen the least discriminatory site.

Because the State failed to present any evidence to rebut the plaintiff's prima facie case, we must remand. Plaintiffs have established a prima facie case of discrimination against the handicapped. The State now has the burden of coming forward with some substantial justification for the adoption of the plan with the greater discriminatory impact. Or the State may demonstrate that the alternative method offered by Appellants will not accomplish the State's objective of cost-saving.[10]

II.

Appellants also maintain that the State's decision is contrary to the best interests of Tennessee Medicaid recipients. Thus, it is

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In *Bryan*, the court refused to require the defendant to consider alternative sites. But in its discussion of this issue, the court cautioned, "We do not foreclose the possibility of a situation where some arrangement, other than the closing of a facility, has such obvious advantages that it must be considered as an alternative to a closing with a significant disproportionate impact." *Id.* at 619. We think that an alternative plan which promises to provide better health service at comparable costs is of such importance that it must at least be considered by the state when the proposed plan would adversely affect the health care of handicapped persons.

[10] We are at a loss to explain the statement in the dissenting opinion which argues that this analysis "creates a whole new source of challenges to state budgetary decisions" We merely interpret a congressional enactment which requires that participant-states consider the impact of changes in their Medicaid program on certain identifiable groups. These groups include racial groups and the elderly as well as the handicapped. The State, by its own admission, failed to consider the impact of the proposed reductions on any group.

While one might disagree with the congressional decision to include the handicapped in its set of protected individuals, our obligations is to strike a balance between the rights conferred upon the handicapped by Congress and the State's right to structure its Medicaid program as it Chooses *as long as that choice is non-discriminatory.*

contended, the reduction violates section 1396a(a)(19) of the Medicaid Act, 42 U.S.C. §1396a(1)(19).[11]

The only authority cited by appellants is *Budnicki* v. *Beal,* 450 F.Supp. 546 (E.D. Pa. 1978). In *Budnicki,* the court held than an alteration in a state's Medicaid program will meet 1396a(a)(19)'s standards if it is "not irrational, or arbitrary and counterproductive to the medical well-being of all Medicaid recipients." *Id.* at 557. *Accord Philadelphia Welfare Rights Organization* v. *O'Bannon,* 517 F.Supp. 501, 508 (E.D. Pa. 1981) aff'd, 681 F. 2d 808 3rd Cir. 1982).

Assuming that this is the correct standard, there is no basis foı finding the state's proposed reductions to be arbitrary or counterprductive to the interests of al lMedicaid recipients. If the fourteen day per annum limitation is implemented, ninety-five percent of all Medicaid recipients will have their hospitalization needs met. Though this court might have fashioned a different set of priorities, the best interests criteria do not transform this court into an administrative body.

III.

The final issue on appeal is whether the State was required to obtain approval from the Secretary of Health and Human Services before adopting the new changes. The parties stipulated that the reduction in hospital coverage had not been approved.

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[11] 42 U.S.C. 1396a(a)(19) provides,

(a) A State plan for medical assistance must —

• • •

(19) provide such safeguardes as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients.

The district court held that prior approval was not required. *Jennings,* 518 F.Supp. at 888. We agree.

42 U.S.C. §1396c provides that the Secretary may terminate federal funding for the Medicaid program of a state if he finds:

> (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a . . .; or
>
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision.

This standard clearly contemplates the adoption of changes in the original plan without prior approval from the Secretary. However, if the changes are subsequently determined to place the State out of compliance with federal regulations, the Secretary may impose sanctions on the State's entire Medicaid program or that portion which is unsatisfactory. Only when the proposed alteration involves a change in reimbursement method is prior approval necessary. 42 U.S.C. §447.261.

As the district court noted, the states have wide latitude in the modification of their plans. Only when the plan is out of conformity with federal statutory requirements will the federal administrators intervene. While "Congress could easily have provided that no state plan could be modified without approval of the Secretary, [it] instead authorized the Secretary to invoke sanctions when modifications were found to be out of compliance with the statute." *Jennings,* 518 F. Supp. at 888.

IV.

In sum, we vacate the district court's judgment and remand for a determination in the following manner. The State should be required to provide a substantial justification for its choice of a reduction in inpatient hospital days when equal savings could be achieved by limiting the number of admissions covered by Medicaid. *Kampmeier* v. *Nyquist,* 553 F.2d 296, 299 (2d Cir. 1977) ("substantial justification" for the policy); *New York*

State Association for Retarded Children v. *Carey*, 612 F.2d at 650 ("must make at least some substantial showing in court that its plan is justified"). The State could also meet its burden by proving that a limit on the number of admissions will not yield the same amount of cost savings achieved by the State's per day restriction.[12] Second, we hold that Appellants have not established that the proposed changes are inconsistent with the best interests of Medicaid recipients. If the changes are eventually implemented, ninety five percent of the State's Medicaid recipients will be served. Though we do have some concerns about the manner in which the original changes were adopted, we cannot say that the changes were irrational or arbitrary. Finally, we hold that the State is not required to obtain approval from the Secretary of Health and Human Services before the proposed changes become final.

Accordingly, the case is remanded for further proceedings not inconsistent with this opinion.

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[12] In light of the dissent's mischaracterization of our holding in this case, we find it necessary to add the following observations. These observations should put to rest any thoughts that we are making it impossible or even difficult for Tennessee or any state to amend its Medicaid Plan.

First, contrary to the dissent's assertions, we are not making a finding of discrimination. We intimate no views on the ultimate outcome of this litigation. The dissent betrays a fundamental misunderstanding of antidiscrimination law by refusing to recognize the difference between a *prima facie* case of discrimination and an actual finding of discriminaton.

Second, contrary to the dissent's assertion, we readily acknowledge the factual distinction between this case and the relocation of the inner-city hospital in *The Medical Center*. However, the two cases warrant similar analysis. That analysis only requires the state to explain why it imposes a needless burden on groups protected by section 504.

Merritt, Circuit Judge, dissenting. Assuming *arguendo* that it is appropriate for a federal court to reach the question, I agree with the Court's holding in Part II that the state's Medicaid plan is not "contrary to the best interest" of Medicaid recipients under 42 U.S.C. §1396(a)(19) (1976). I also agree with Part III of the opinion that the adoption of the Medicaid plan in Tennessee was not procedurally deficient.

For the reasons set out below, I disagree, however, with Part I of the opinion that the state of Tennessee may not reduce its Medicaid hospitalization coverage by six days per year without violating "the general corpus of discrimination law," (Majority Opinion p.6), specifically section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794 (1976).

I.

The statute which we must interpret here, §504, provides simply that no "handicapped individual" (defined as a person "regarded" as handicapped who has an "impairment which substantially limits...major life activities") "shall, solely by reason of his handicap...be subject to discrimination" under

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Third, *Southeastern Community College* v. *Davis*, 442 U.S. 397 (1979), cited by the dissent, is simply inapplicable to the facts of this case. We agree with the dissent that if the relief sought by the appellants will require the expenditure of additional funds or impose a burden on the state, then a different case would be presented. We have reviewed the record meticulously and can discover no assertion by the State that it will have to engage in affirmative action to grant the requested relief. In fact, as noted above, the state never even considered the needs of appellants.

In sum, we take exception with the dissent's implication that we are revolutionizing the law under section 504. The dissenting opinon distills into a profound disagreement with the language of the section, and its statutory and regulatory scheme. While any analysis taken to its logical extreme would eventually lead to nihilism, requiring a state to justify what appears to be a violation of the law has not yet sent any state into chaos.

any program receiving federal funds. No further definition of "discrimination" is given.

I believe that the statute seeks only to secure for the handicapped equality of opportunity, or equality of access, in connection with government programs. It does not require a form of affirmative action or equality of results, as my colleagues insist. They hold that the plaintiffs have made a *prima facie* showing that Tennessee discriminated agains the handicapped by reducing Medicaid coverage for inpatient hospital care from twenty to fourteen days per year. They base this holding on a finding that the reduction in coverage will have a disparate impact on some classes of "handicapped" patients (e.g., asthmatic patients): a higher percentage of these classes of "handicapped" recipients will have their *health* adversely affected by the cutback than other recipients. Although budgetary constraints are the reason for the State's action — the State can no longer afford to pay for the longer period of hospitalization — the majority finds discrimination in the method the State has chosen to reduce its budget. Conceding that equality of access is present, the majority says that the state may not make a modification in its program that has a more adverse effect on the health of some group of handicapped individuals that other medical patients. The majority points to the asthmatic patient, assumes without discussion that he is a "handicapped individual" within the meaning of the statute, and finds that the state must provide him with an "equal opportunity to succeed" in achieving good health (see note 8 of the majority opinion) in comparison with other patients.

Without a clear, bright line distinction based on access, like the District Court makes, the Court's decision will create a whole new source of challenges to state budgetary decisions People with physical ailments depend on a myriad of state services more heavily than do people with no ailments. When a local government decides to reduce the quality, frequency or financing for some service, for example, bus service, some group

could make a case of discrimination, for example, by showing that they use the buses more than others. Across-the-board cuts in welfare, social security, education and many other benefits will affect some groups more than others and will open the way to litigation. I do not believe that Congress intended this statute to authorize the federal courts to step in and control the budgetary process when cuts in appropriations affect asthmatics, or some other class of patients, somewhat more heavily than another group of patients.

The substantive right or benefit in question here, according to my colleagues, seems to be good health. Since they find that the budget cut affects the health of asthmatic patients more, they find discrimination. We all want good health for ourselves and others, but there is no constitutional, statutory or other substantive legal right to good health or to equality of "success" in achieving good health through governmental programs.

The Court may be right in its speculation, although I am not convinced by its reasoning or the statistical evidence, that the handicapped as a group, however defined, will be less healthy than the non-handicapped after 14 rather than 20 days in the hospital. But the problem with this assumption, even if true, is that Medicaid does not assure better health. It grants only days of inpatient hospitalization free of charge. Medicaid only gives eligible individuals access to free hospital care for X days per year. Tennessee's decision to reduce the number of days of coverage in order to meet its budgetary requirements reduces free hospital care to the handicapped and non-handicapped equally. As District Judge Morton pointed out:

> Both handicapped and nonhandicapped Medicaid recipients will have identical hospital services available for their use, subject to the same durational limitation. The alleged problem is not with access, but with the end result... [N]either the statute nor the accompanying regulations require a program to achieve identical results for handicapped and nonhandicapped recipients.

Jennings v. *Alexander,* 518 F.Supp. 877, 883 (M.D. Tenn. 1981).

The majority relies heavily on *N.A.A.C.P.* v. *The Medical Center,* 657 F.2d 1322 (3d Cir. 1981), for the proposition that a showing of discriminatory effect establishes a *prima facie* case under Section 504. That reliance is misplaced. The case involves only the question of access to medical facilities, a point the majority does not acknowledge or discuss. The issue in the case was the effect of relocating a medical center. Assuming *arguendo* the application of a disparate impact test, the Third Circuit found that the plaintiffs failed to make a *prima facie* showing that handicapped *access* to treatment would be lessened by the proposed move. It said nothing about the effect of the new facility's services on the health of the handicapped.

A case more analogous to the one before us, discussed extensively by the District Judge, is *Doe* v. *Colautti,* 592 F.2d 704 (3d Cir. 1979). There is a mental patient challenged the Pennsylvania Medicaid law, which provided unlimited inpatient coverage for treatment in private general hospitals but limited coverage for treatment in private mental hospitals to 60 days. Doe claimed this limitation discriminates against the handicapped who are mentally ill. The court held that private mental hospitalization coverage is not required at all and, therefore, the State's decision to provide a different measure of benefits for the two types of impairment does not violate §504. It reasoned that §504 does not "obliterate the distinctions between the medical care a state medical assistance program must cover and the care it need not include." *Id.* at 710. It is this same distinction that my colleagues have "obliterated" in this case.

The recent Supreme Court case, *Southeastern Community College* v. *Davis,* 442 U.S. 397 (1979), delivers the *coup de grace* to the theory of equal treatment the majority seeks to estabish in this case. In the *Southeastern Community College* case, Justice Powell, writing for a unanimous Court, held that a state's

refusal to make modifications in its nursing education program to accommodate a deaf applicant does not violate §504. Responding to plaintiff's argument that §504 "requires Southeastern to make the kind of adjustments that would be necessary to permit her safe participation in the nursing program," the Court stated that §504 does not "compel Southeastern to undertake affirmative action." 442 U.S. 407, 409. Rather "the language and structure" of the Act "reflect a recognition by Congress of the distinction between the evenhanded treatment of qualified handicapped persons and affirmative efforts to overcome the disabilities caused by handicaps." 442 U.S. at 410.[1] It is precisely this distinction between evenhanded treatment by the state and equality of results that my colleagues fail to recognize.

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[1] The Court discussed and ruled on this distinction in the following two paragraphs:

> The language and structure of the Rehabilitation Act of 1973 reflect a recognition by Congress of the distinction between the evenhanded treatment of qualified handicapped persons and affirmative efforts to overcome the disabilities caused by handicaps. Section 501(b), governing the employment of handicapped individuals by the Federal Government, requires each federal agency to submit "an affirmative action program plan for the hiring, placement, and advancement of handicapped individuals . . ." These plans "shall include a description of the extent to which the methods whereby the special needs of handicapped employees are being met." Similarly, §503(a), governing hiring by federal contractors, requires employers to "take affirmative action to employ and advance in employment qualified handicapped individuals . . ." The President is required to promulgate regulations to enforce this section.
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> Under §501(c) of the Act, by contrast, state agencies such as Southeastern are only "encourage[d] . . . to adopt and implement such policies and procedures." Section 504 does not refer at all to affirmative action, and except as it applies to federal employers it does not provide for implementation by administrative action. A comparison of these provisions demonstrates that Congress understood acommodation of the needs of handicapped individuals may require affirmative action and knew how to provide for it in those instances where it wished to do so.

442 U.S. 410-11.

II.

It is highly questionable whether a disparate impact test should be applied under §504. This case appears to be the first federal appellate court opinion which actually finds discrimination against the handicapped by applying a "disparate impact" test. *The Medical Center* found no *prima facie* case, even assuming the applicability of such a test. My research discloses no other appellate case that suggests that such a test is applicable under section 504, and there is now substantial doubt that the test is applicable under Title VI of the 1964 Civil Rights Act, 42 U.S.C. §2000d (1976), the provision the majority points to as the analogue for §504. *See Cannon* v. *University of Chicago,* 648 F.2d 1104, 1106-09 (7th Cir. 1981) (disproportionate impact does not establish a Title VI violation; discriminatory intent required); *Guardians Ass'n of New York* v. *Civil Service Comm'n of the City of New York,* 633 F.2d 232, 254, 272-275 (2d Cir. 1980) (same). The unsatisfactory nature of the disparate impact test is intelligently discussed in Eisenberg, *Disparate Impact,* 52 N.Y.U.L. Rev. 36 (1977), an article which proposes a better test of causation in discrimination cases.

Assuming *arguendo* the applicability of a disparate impact test, this case illustrates why such a test will not work unless a bright-line equality of access standard is used. Combining an equality of results standard with a disaprate impact test means the plaintiff always wins.

According to the majority's interpretation of the statute, a plausible interpretation in light of the broad language of the statute, there are many sub-classes of patients who fall within the "handicapped" category, not just traditional groups like the blind, the deaf and the lame. The majority's list would seem to include any serious, limiting physical or mental ailment, from asthma and arthritis to alcoholism and drug addiction. Any reduction in funding or services will have a differential impact on some class of patients. In such a situation the disparate im-

pact test will always work for some class of illness; it will always produce a finding of discrimination. The alternative solution suggested by the majority — a limitation based on the number of trips to the hospital during the year rather than the number of days — will fall hardest on the class of patients who must come often to the hospital for short stays. It is clear that the majority's alternative would also produce a finding of discrimination if its disparate impact analysis is to be carried to its logical conclusion.

There appears to be no way under the set of standards developed by the majority that a state can modify its medical program without some disparate impact on some class of patients — unless the state simply abolishes Medicaid altogether, a solution that would presumably be equal only because it denies relief to everyone. Obviously, neither the majority nor I want to encourage that kind of nihilistic solution, which requires that everyone should fail so that no one will succeed more than another — the ultimate in equality of results.

For these reasons, I respectfully but strongly disagree with the majority and would affirm the judgment of the District Court.

APPENDIX B

Rosier Jennings, et al.,

v.

Lamar Alexander, et al.,

No. 80-2043-NE-CV.

United States District Court,
M. D. Tennessee,
Northeastern Division.

June 17, 1981.

MEMORANDUM

MORTON, Chief Judge.

The plaintiffs in this case, all recipients of Medicaid benefits in Tennessee, seek to permanently enjoin the state's proposed reduction in Medicaid coverage for inpatient hospital care from the current limit of 20 days per year to a proposed maximum of 14 days per year. Although the complaint originally challenged a comprehensive array of proposed changes, and as recently as the March 13, 1981, bench trial also challenged various changes in the Medicaid drug formulary, the parties have now reached agreed settlements on all issues except the reduction in inpatient hospital coverage.

On September 3, 1980, this court preliminarily enjoined all the challenged reductions in Medicaid coverage, such injunction to remain in effect until further order of the court. The basis for that injunction was the state's failure to consult a properly constituted Medicaid Medical Care Advisory Committee prior to proposing the changes in violation of 42 U.S.C. § 1396a(a)(4) and 42 C.F.R. § 431.12. *Jennings* v. *Alexander,* No. 80-2043, Memorandum Opinion Sept. 3, 1980. It now appears that a pro-

perly constituted advisory committee has been given adequate opportunity to participate in formulating proposed changes in the Medicaid program, and therefore the reason for which the preliminary injunction was granted no longer exists. Thus, the court will examine the arguments specifically raised against the proposed reduction in coverage for inpatient hospital care to determine whether the injunction as to that proposal should be lifted, extended or made permanent.

As noted in the Memorandum Opinion of September 3, 1980, this court has subject matter jurisdiction under both 28 U.S.C. §§ 1331 and 1343. *See Hagans* v. *Lavine,* 415 U.S. 528, 94 S.Ct. 1372, 39 L.Ed.2d 577 (1974); and *Bell* v. *Hood,* 327 U.S. 678, 66 S.Ct. 773, 90 L.Ed. 939 (1946). That jurisdiction has not been challenged.

General background on the Medicaid program in Tennessee is provided in the September 3, 1980, Memorandum Opinion and is adopted herein by reference. For present purposes, it will suffice to reiterate that Medicaid is a cooperative undertaking of the federal and state governments, and that while participation by the state is voluntary, once the state decides to participate, it must do so in compliance with the requirements of Title XIX of the Social Security Act of 1965, 42 U.S.C. § 1396 *et seq.*, (hereinafter sometimes referred to as Title XIX) and the applicable federal regulations. *Harris* v. *McRae,* 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980), *reh. den.* 448 U.S. 917, 101 S.Ct. 39, 65 L.Ed.2d 1180 (1980).

The plaintiffs have raised four general arguments against the proposed reduction in hospital coverage to a maximum of 14 days per year. First, it is argued that the limitation will discriminate against handicapped Medicaid recipients in violation of section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (hereinafter "§ 504"), and the regulations promulgated thereunder. Second, the plaintiffs contend that the reduction is inconsistent with the best interests of Medicaid recipients, in violation of 42 U.S.C. § 1396a(a)(19). Third, it is argued that

any reduction in services is invalid without prior approval of the Secretary of Health and Human Services. The parties have stipulated that no such approval has been obtained. Finally, the plaintiffs contend that the injunction should remain in effect because of the state's failure to publish notice of the proposed change as required by 42 C.F.R. § 447.205. The court will address these contentions *seriatim*.

Alleged Discrimination Under § 504

The argument that the proposed reduction in inpatient hospital coverage to 14 days per year will discriminate against handicapped Medicaid recipients in violation of § 504 raises interesting questions of both law and fact. The court must first determine whether the plaintiffs have shown that the proposed limitation will have the alleged discriminatory impact if it is implemented. If the plaintiffs have met their burden of persuasion on the threshold issue of discriminatory impact, the court must then address what is apparently an issue of first impression: That is, whether a ceiling on coverage for required Medicaid services which adversely affects a greater percentage of handicapped than non-handicapped Medicaid recipients amounts to discrimination "solely by reason of . . . handicap," in violation of § 504.

Section 504 provides in relevant part as follows:

> No otherwise qualified handicapped individual . . . as defined in section 706(7) of this title, shall, *solely by reason of his handicap,* be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

29 U.S.C. § 794 (emphasis added). The relevant portion of the statutory definition of "handicapped individual" reads:

> [A]ny person who (i) has a physical or mental impairment which substantially limits one or more of such per-

son's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment.

29 U.S.C. § 706(7)(B).

Regulations duly promulgated pursuant to § 504, and specifically applicable to health, welfare and social service programs, further refine the concept of discrimination on the basis of handicap. 45 C.F.R. § 84.52(a) provides that:

> *General.* In providing health, welfare, or other social services, a recipient [of federal funds] may not, on the basis of handicap:
>
> (1) Deny a qualified handicapped person these benefits or services;
>
> (2) Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered nonhandicapped persons;
>
> (3) Provide a qualified handicapped person with benefits or services that are not as effective (as defined in § 84.4(b)) as the benefits or services provided to others;
>
> (4) Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons; or
>
> (5) Provide different or separate benefits or services to handicapped persons except where necessary to provide qualified handicapped persons with benefits and services that are as effective as those provided to others.

In order for a service to be as effective in serving the handicapped as it is in serving others, such services or benefits

> are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons lequal opportunity to obtain, or to reach the same level of achievement.

45 U.S.C. § 84.4(b)(2).

It is undisputed that the State of Tennessee is a recipient of federal funds in connection with the Medicaid program, and thus that the program is within the scope of § 504 and the regulations cited above. It is likewise undisputed that a number of recipients of Medicaid benefits in Tennessee, including certain of the named plaintiffs in this action[1] are "handicapped individuals" as that term is defined in the Rehabilitation Act, 29 U.S.C. § 706(7)(B), *supra*. Therefore, those plaintiffs have standing to challenge the proposed reduction.[2]

Evidence presented at the trial of this case established that for fiscal year 1979-80, 341,960 persons were eligible for Medicaid benefits in Tennessee. Of these, 90,668 were classified as handicapped. For the period between July 1, 1979 and June 30, 1980, 51,140 Medicaid recipients utilized one or more days of

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[1] The complaint sought class action certification as to the class of Medicaid recipients generally, as well as to various subclasses, including handicapped recipients. No hearing was held and no determination was made on the propriety of certifying any of the subclasses. Such certification would probably have been unnecessary in any event, since injunctive relief if granted would have necessarily benefitted all recipients, but in view of the court's decision to deny the § 504 claim on the merits, it is clearly not necessary to decide whether the subclass should be certified.

[2] It is generally accepted, and has not been challenged here, that § 504 creates an implied private right of action for handicapped individuals allegedly subjected to unlawful discrimination. *See Lynch* v. *Maher*, 507 F.Supp. 1268 (D.Conn. 1981); *Camenisch* v. *University of Texas*, 616 F.2d 127 (5th Cir. 1980) (*vacated and remanded on other grounds*, 449 U.S. 1075, 101 S.Ct. 853, 66 L.Ed.2d 797 (1981). *See also* cases cited in *Camenisch*, *supra*, 616 F.2d at 131, and S.Rep.No. 93-1297, 93rd Cong. 2d Sess. 39-40, *reprinted in* 4 U.S. Code Cong. & Ad.News 6373, 6391 (1974).

inpatient hospital care.[3] Of these Medicaid users of inpatient hospital care, 16,852 were handicapped and 34,288 were nonhandicapped.[4] The evidence further showed that for the fiscal year examined, 72.6% of the handicapped users would have been fully served by 14 days of hospital inpatient coverage. Stated otherwise, 27.4% of all handicapped users in 1979-80 needed more than 14 days of inpatient hospital treatment. By contrast, 92.2% of all nonhandicapped users were fully served at 14 days or less, leaving only 7.8% in need of inpatient hospital care beyond the 14th day.

Other testimony compared inpatient hospital utilization rates for handicapped and nonhandicapped users on the basis of "recipient years of eligibility" rather than the straight calculation of days of service used. The purpose of the latter calculation was to compensate for an apparent inflation of figures that results from handicapped users requiring year-round treatment, compared with others who required service only periodically. Without going into detail, suffice to say that this evidence also showed substantial disparity. For the year 1979-80, the utilization rate for handicapped was 60.1 recipients per thousand recipient years of eligibility, compared with 11.3 recipients per thousand recipient years eligibility for nonhandicapped.

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[3] There is a discrepancy of 70 recipients between two exhibits which purport to reflect total inpatient usage for the same year. Exhibit D-6c, which shows subtotals for handicapped and nonhandicapped groups, is the source of the 51,140 figure. Exhibit D-4a, broken down according to categorically needy and medically needy shows a total usage of 51,070. The court's choice of the former was based on the need to compare the handicapped and nonhandicapped, but the analysis would not be affected by a total reduction of 70 users.

[4] Thus, 18.586% of handicapped eligibles received one or more days of inpatient hospital care, as compared with 13.644% of nonhandicapped eligibles. This relatively small percentage of total persons eligible for Medicaid care constitutes the group referred to herein as "users."

The plaintiffs use these figures to argue that the proposed 14-day limitation will have a disparate impact upon handicapped Medicaid recipients. They point out that the percentage of handicapped users not fully served at day 14 was almost four times as great as the percentage of nonhandicapped users who needed more than 14 days' coverage per year. Because of this apparent disparity, the plaintiffs contend that handicapped recipients subject to a 14-day limitation would be denied access to services offered to nonhandicapped recipients, and that the inpatient services available to the handicapped would be less effective than the services available to the nonhandicapped recipients, in violation of § 504 and 45 C.F.R. § 84.52(a), *supra*. It is also argued that this reduction in services would work to impair the accomplishment of the objectives of Title XIX, as stated in 42 U.S.C. § 1396, in specific violation of 45 C.F.R. § 84.4(b)(4).[5]

The court concludes that the plaintiffs' arguments must fail for two independent but equally compelling reasons. First, the court finds that the plaintiffs have failed to carry their burden of establishing that the limitation of 14 days of hospital

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[5] 42 U.S.C. § 1396 provides, in relevant part, that the purposes of the Medicaid Act include furnishing:

> (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care....

45 C.F.R. § 84.4(b)(4) provides in relevant part:

> A recipient [of federal funds] may not ... utilize criteria or methods of administration ... (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect to handicapped persons.

coverage will in fact have a discriminatory impact upon handicapped Medicaid recipients. Second, even if the evidence were found to establish that a disparate impact upon the handicapped as a statistical group would result from the limitation, the court would hold that such an impact is not the type of discrimination that § 504 was intended to proscribe.

From the evidence presented, there can be no doubt that if a 14-day limit on inpatient hospital coverage had been in effect in fiscal year 1979-80, the impact upon the handicapped as a statistical group would have been greater than the impact upon the nonhandicapped. However, there does not appear to be any sound basis for concluding that a similar disparity would necessarily result in another year subject to such a limitation. No evidence was offered that the ratio of handicapped to nonhandicapped inpatient hospital usage remains in any sense constant from year to year. Rather, the evidence on the issue of disparate impact consisted entirely of various analyses of statistics for a single fiscal year, and thus established no foundation for a proper extension of the figures into the future.

[1] Furthermore, the plaintiff's argument assumes that the presence of handicaps in fact accounts for the statistically higher hospital usage by the handicapped group. Such an assumption is not compelled, even for the 1979-80 year, and no evidence was offered which might convincingly warrant it.[6]

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[6] For example, there was no attempt to show what percentage of handicapped users required inpatient hospital treatment as a result of their handicapping condition. It seems likely that some handicaps, such as blindness, would rarely require hospitalization, while others, such as mental illness, might well require frequent hospitalization. Without some such evidence, the court is left to speculate on what extent the existence of handicaps in the broad sense of § 504 affects the statistical disparity shown for the study year. Indeed, the actual impact of the proposed limitation, even in the study year, should be kept in perspective. Since only 18.586% of handicapped eligibles used any inpatient hospital services, and 27.4% of those needed more than 14 days, only about 5% of the handicapped eligibles were in need of more that 14 days of hospital treatment. Thus, 95% would have been fully served at 14 days.

Thus the plaintiffs' argument requires both an assumption as to causation and an inference that the 1979-80 figures are representative of likely future hospital usage, neither of which is warranted. And the court will not base its holding on mere speculation. Therefore, the court holds that the plaintiffs have failed to establish a prima facie case that the proposed limitation on inpatient hospital coverage to 14 days per year will have a discriminatory impact upon handicapped Medicaid recipients.

Even if the disparity shown in 1979-80 were assumed to be representative of future trends in Medicaid usage, the court does not believe that a violation of § 504 would have been established. The section proscribes discrimination "solely by reason of . . . handicap." 29 U.S.C. § 794. As previously stated, the evidence in this case failed to show any causal connection between the existence of handicaps and the need for hospital care in excess of 14 days. The statistics merely revealed a correlation for the study year between handicapped users and a need for more days of hospital care than nonhandicapped users. Since there was no evidence that the presence of handicaps was the reason that the handicapped group seemed to require an average of more days of hospital care, it is difficult to conceive how the disparity could be considered discrimination "solely by reason of . . . handicap."

The plaintiffs contend that the mere existence of a disparity is sufficient to make out a prima facie case of discrimination under § 504. They argue that the section proscribes discriminatory effect, and that nothing else need be shown, citing cases in which facially neutral programs were held violative of § 504, *e.g.*, *N.A.A.C.P.* v. *Wilmington Medical Center, Inc.*, 491 F.Supp. 290 (D.Del. 1980); *Lloyd* v. *Regional Transportation Authority*, 548 F.2d 1277 (7th Cir. 1977); *New Mexico Association for Retarded Citizens* v. *State of New Mexico*, 495 F.Supp. 391 (D.N.Mex. 1980). The plaintiffs also point to 45 C.F.R. § 84.4(b)(4), *supra*, and its prohibition of "criteria or methods of administration" with the effect of discriminating

against the handicapped. Finally, reliance is placed upon the Department of Health, Education and Welfare's May 17, 1976, Statement of Policy interpreting § 504, which states:

> [h]andicapped persons may require different treatment in order to be afforded equal access to federally assisted programs and activities, and identical treatment may, in fact, constitute discrimination.

41 Fed.Reg. 20296 (May 17, 1976). Thus, the plaintiffs argue that the proposed limitation of inpatient hospital services to 14 days per year, although facially neutral, in effect discriminates against the handicapped and must be remedied by implementing some alternative criteria.[7]

The court does not believe that any of the cited authority is dispositive of the instant case. *N.A.A.C.P.* v. *Wilmington Medical Center, Inc., supra,* concerned, inter alia, allegations that the relocation of an inner-city hospital to the suburbs would disporportionately affect handicapped as well as minority persons in the service area. The court discussed the appropriate test for alleged violations of § 504 and adopted an "adverse impact" test. The court said that § 504

> requires that recipients of federal funds take affirmative action to make their programs equally accessible to the handicapped as well as forbidding them from taking actions which will have a disparate adverse effect upon the handicapped. Failure to comply with either requirement constitutes a *prima facie* violation of Section 504.

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[7] The plaintiffs ask the court to either require the continuance of the current 20-day limitation, or, if the court should determine that the present limitation also creates a disparate adverse effect, order the implementation of an alternative proposal limiting hospital stays on a per-stay basis, rather that a per-year basis. Some evidence was admitted to the effect that the latter proposal would result in reducing the cost to the state of the inpatient services, without a disparate impact upon handicapped.

491 F.Supp. at 317-18. However, the court went on to note the provisions of 45 C.F.R. § 84.4(b)(2), *supra,* to the effect that identical results are not required, and stated that as long as the handicapped were "given access to medical care equal to what afforded the general population, no discrimination will be found." *Id.*, at 318. The court then held that on the facts before it, no prima facie case had been established under § 504.

Thus, it is far from clear that the *Wilmington Medical Center* court intended to adopt as strict an "impact test" as the plaintiffs contend. Rather, it would appear that the court recognized that a program need not be equally productive for handicapped and nonhandicapped alike, as long as the program is equally accessible to both groups.

In the case at bar, the plaintiff's initial argument that the handicapped will be denied access to Medicaid inpatient hospital services if the proposed limitation is implemented, is simply untenable. Both handicapped and nonhandicapped Medicaid recipients will have identical hospital services available for their use, subject to the same durational limitation. The alleged problem is not with access, but with the end result. And, as the *Wilmington Medical Center* court recognized neither the statute nor the accompanying regulations require a program to achieve identical results for handicapped and nonhandicapped recipients.

Although *Lloyd* v. *Regional Transportation Authority, supra,* contains language indicating that a strict discriminatory impact test ought to be applied to § 504 cases, the court in that case did not apply the test, but merely vacated the district court's summary dismissal and remanded for a decision on the merits. In addition, the court's concern in *Lloyd* was clearly with the inability of mobility handicapped persons to gain access to urban transportation. As stated, *supra,* the court cannot concieve how the present case can be characterized as a denial of access to services.

Furthermore, the alleged discrimination in *Lloyd* resulted from the very existence of a particular genre of physical impairment, i.e., those conditions requiring confinement to a wheelchair, and was thus squarely within the § 504 prohibition of discrimination "solely by reason of ... handicap." In the present case, it is not a particular handicap which is allegedly subject to discrimination. Rather, the plaintiffs contend that the entire range of handicapped persons, within the broad definition of that term, 29 U.S.C. § 706(7)(B), *supra,* taken as a statistical group, are subjected to discrimination by virtue of the asserted greater need for more inpatient hospital care than other Medicaid recipients. As explained, *infra,* this court does not believe that § 504 goes that far.

New Mexico Association for Retarded Citizens v. *State of New Mexico, supra,* is arguably more helpful to the plaintiffs here. The court therein found state and local school boards in violation of §504 and the accompanying regulations for failure to provide a free appropriate public education to students suffering from mental retardation and learning disabilities. The court in that case also adopted an impact test and issued a mandatory injunction requiring affirmative action to comply with the statutory and regulatory requirements.

However, the *New Mexico* case, like *Lloyd,* involved clear discrimination on the basis of specific disabilities. In addition, the failure of the defendants in *New Mexico* to take appropriate steps to adequately educate the state's handicapped children amounted to a *de facto* denial of access to the state's public educational services. Just as persons confined to wheelchairs are denied access to city buses they are unable to mount, retarded children are denied education in a classroom where teachers and techniques are suitable only for "normal" children. The plaintiffs in *New Mexico* sought only an equal opportunity to be educated; they sought meaningful access to some education where all had been effectively denied. They did not, as the plaintiffs do here, seek additional services to ensure that they emerged from

the schools with the best education possible, or to guarantee that relatively identical percentages of handicapped and nonhandicapped children would emerge from school adequately educated. In short, the *New Mexico* plaintiffs were concerned with meaningful access; the plaintiffs here are concerned with similarity of results.

Similarly, the HEW Statement of Policy is apparently concerned with access. No indication is given that the agency ever envisioned mandating equal results for handicapped and nonhandicapped. To the contrary, 45 C.F.R. §84.4(b)(2), *supra*, squarely refutes any such intention.

In the case most closely on point to the case at bar, the plaintiffs challenged a limtation in Pennsylvania's Medicaid coverage to 60 days per year for inpatient care in a private mental institution, when no such limt existed on inpatient hospital care for physical illness. *Doe v. Colautti*, 592 F.2d 704 (3d Cir. 1979). In affirming the district court's denial of a prelimnary injunction, the court noted that care in a mental institution was an optional Medicaid service, which participating states may but need not provide, while inpatient hospital care for physical prblems is a required service. The court held that §504 could not have been intended to negate the distinction between the two types fo services which Congress had expressly allowed in the Medicaid Act, and further noted that patients with mental handicaps were allowed full treatment for physical ailments, just as nonhandicapped recipients. Thus, the court could not find the likelihood of prevailing on a §504 claim sufficient to support a preliminary injunction.

The present case can be distinguished from *Colautti* in that here the challenged limitation will affect a mandatory Medicaid service rather than an optional one. However, if the limitation is allowable under Title XIX, then the distinction becomes meaningless. The court determines that states may legitimately limit the inpatient hospital care provided under their Medicaid plans,

and further that the particular limitation proposed in this case is allowable.[8]

While some coverage for inpatient hospital care must be provided in the state's Medicaid plan, 42 U.S.C. §§1396a(a)(13) and 1396d(a), there is no requirement that Medicaid pay for all such services needed. Indeed, the specific requirement for provision of inpatient hospital services is included as part of the definition of "medical assistance," which expressly allows for "payment of *part or all* of the cost of the [required] care and services." 42 U.S.C. §1396d(a) (emphasis added). Thus, the states are allowed to set reasonable limits on the amount, scope and duration of services provided under the Medicaid program. *See Beal v. Doe*, 432 U.S. 438, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977). The court holds that a proposed limitation which, even when the evidence is considered most favorably to the plaintiffs, would fully serve at least 95% of the group allegedly most harmed by the limitation,[9] is reasonable and is allowed under Title XIX. In the absence of some indication of contrary Congressional intent, § 504 will not be read as invalidating this otherwise allowable limitation. *See Colautti, supra.*

While agreeing that a disparate impact test is the appropriate standard to apply in a §504 case, the court holds that the adverse impact arguably shown in this case does not amount to discrimination under §504. This conclusion is based upon several factors.

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[8] As explained, *infra*, the court finds that the plaintiff's argument for enjoining the reduction of benefits on the ground that it is inconsistent with the best interests of Medicaid recipients to be without merit. Similarly, the court holds that the reduction will not impair the accomplishment of the objectives of Title XIX.

[9] *See* Note 6, *supra*.

First, and most importantly,, the court is convinced that the statutory language prohibiting discrimination "solely by reason of...handicap" does not encompass the kind of disparity which the plaintiffs attempted to show in this case. Assuming, *arguendo,* that the plaintiffs had successfully established that the proposed limitation would have a disparate adverse impact upon handicapped Medicaid recipients taken as a statistical group (a question previously resolved against the plaintiffs), such an impact would not be by reason of any handicap. In reaching this conclusion, the court notes that both handicapped and nonhandicapped Medicaid recipients have full and unquestioned access to the same type and duration of inpatient treatment. Furthermore, the same durational limt works without regard to any particular handicapping condition and regardless of the particular cause of hospitalization. Indeed, it might well be assumed that of those Medicaid recipients subject to a particular handicap, some will be fully served by 14 days of inpatient care, while others will need further treatment. Coverage will be terminated under the proposed limitation when a particular recipient has exhausted the 14 days of coverage, whether the recipient is handicapped or not. The court can find no discrimination by reason of handicap.

In addition, any disparate adverse impact which the plaintiffs may have shown would be evident only in terms of the end result, and therefore under 45 C.F.R. §84.4(b)(2), *supra,* could not amount to a denial of equally effective services. THe handicapped and nonhandicapped will be afforded equal care in both quality and quantity, and the claim that fewer handicapped than nonhandicapped will be fully served does not establish a violation of §504.

Finally, although the court is persuaded that some level of a disparate impact test is the appropriate standard to apply, it is clear that not all federally funded programs which fail to serve the handicapped and nonhandicapped on an equal basis can be held in violation of §504. For example, in *Southeastern Com-*

munity College v. *Davis,* 442 U.S. 397, 99 S.Ct. 2361, 60 L.Ed.2d 980 (1979), the Court refused to find a violation of §504 where a state refused to take affirmative action to make its nursing program fully accessible to a deaf student. That case contains some rather broad language which calls into question whether affirmative action is ever required under §504. *Id.,* 442 U.S. at 411-12, 99 S.Ct. at 2369-70, 60 L.Ed.2d at 991-92.

More recently, it has been held that Department of Transportation regulations requiring affirmative action to make urban transportation systems fully accesible to mobility handicapped individuals were not within the department's authority to promulgate under §504. *American Public Transit Association* v. *Lewis* (D.C.Cir. May 26, 1981), *see* synopsis at 49 U.S.L.W. 2756. This case is important, since it provides a post-*Southeastern Community College* analysis fo the one area in which §504 had been consistently held to require affirmative action to remedy disparate impact in a facially neutral program,[10] and thus demonstrates the court's belief that the results reached in the prior cases are untenable in view of the Supreme Court's decision in *Southeastern Community College.*

These two cases alone would compel the conclusion that the kind of statistical impact asserted by the plaintiffs in the case at bar does not amount to a violation of §504. Additionally, even if some disparate impact were to have been established, the court does not believe that, under the analysis of the Court in *Southeastern Community College,* affirmative relief would be warranted.

In summary, the court holds that §504 does not require a state to structure its Medicaid program so that relatively equal per-

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[10] *See, e.g., United Handicapped Federation v. Andre,* 558 F.2d 413 (8th Cir. 1977); *Leary v. Crapsey,* 566 F.2d 863(2d Cir. 1977); *Lloyd* v. *Regional Transportation Authority,* 548 F.2d 1277 (7th Cir. 1977); *Bartels* v. *Biernat,* 427 F. Supp. 226 (E.D.Wis.1977).

centages of handicapped and nonhandicapped recipients are fully served by a particular type of benefit, as long as the benefit is equally availble to both groups. So long as a service is offered in equal quality, scope and duration to both handicapped and nonhandicapped recipients, and handicapped recipients are actually afforded equal access to that service, the mandates of §504 have been satisfied. The State of Tennessee's proposed limitation on inpatient hospital coverage to 14 days per year operates without regard to handicap, provides services that are equally available to all Medicaid recipients, and thus does not violate §504.

The "Best Interest" Requirement

The palintiffs next contend that the proposed limitation is in violation of 42 U.S.C. §1396a(a)(19), which provides as follows:

> (a) A state plan for medical assistance must —
>
> ....
>
> (19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided in a manner consistent with...the best interests of the recipients.

It is argued that the best interests of the plaintiffs require that any reductions in Medicaid services be made with the least injury possible to Medicaid recipients. The plaintiffs argue that this goal can best be accomplished by implementation of a limitation based upon days per hospital stay, rather than total days per year. As noted previously, some evidence was offered that such a limitation would achieve the desired cost savings, without the asserted disparate impact upon handicapped recipients.

In support of their position, the plaintiffs rely primarily upon two cases dealing with Medicaid coverage of medically neces-

sary abortions, *Hodgson* v. *Board of County Commissioners,* 614 F.2d 829 (3rd Cir. 1980). However, neither of these cases is particularly helpful in resolving the question presently before the court. The *Hodgson* court bsaed its holding upon a finding that Minnesota's restriction on Medicaid payments for abortions to those necessary to save the life of the mother, or in cases of rape or incest, was an impermissible denial of medical care on the basis of diagnosis, type of illness or condition. 614 F.2d at 608. The best interest requirement was cited, but never expressly discussed nor relied upon.

In *Casey,* the court held that Pennsylvania's refusal to fund abortions except when necessary to save the life of the mother was in violation of the requirments of Title XIX, as modified by the "Hyde Amendment" to the 1980 Appropriation Act, P.L. 96-123, §109, 93 Stat. 926 (1979) but again failed to include any discussion of the best interest requirement. Rather, it appears that the decision of the district court in that case was again based on a finding of discrimination on the basis of diagnosis, type of illness or condition. Thus, the majority of the court of appeals panel never directly discussed the "best interest" argument. The concurring judge would have found the state statute in violation of the best interest requirement as well as the prohibition of discrimination because of type of condition. 623 F.2d at 839-40 (Hunter, J., concurring). But Judge Hunter did not offer even the slightest explanation of the appropriate standard for judging whether a state service limitation is in the best interests of Medicaid recipients, and thus his opinion provides little guidance for future application of the requirement.

The statute relied upon by plaintiffs, 42 U.S.C. §1396a(a)(19), *supra,* appears as part of the general requirements for state plans which must be approved by the Secretary of Health and Human Services prior tothe state's receipt of federal funds for the Medicaid program. *See* 42 U.S.C. §1396. The provision was included in the original version of Title XIX, as part of the 1965 amendments to the Social Security Act. The purpose of the section was stated to be:

> [To] provide some assurance that the States will not use unduly complicated methods of determining eligibility which have the effect of delaying in an unwarranted fashion the decision on eligibiity for medical assistance or that the states will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided.

S.Rep.No.404, 89th Cong., 1st Sess., *reprinted in* [1965] U.S. Code Cong. & Ad. News 1943, at 2017.

The present case raises the question whether the proposed limitation should be held invalid because it allegedly adversely affects the availability of inpatient hospital services to handicapped recipients, in spite of the existence of a less burdensome alternative. However, in light of the court's decision that the plaintiffs have failed to show that the limitation will have a discriminatory impact on handicapped recipients, it would be incongruous indeed to now hold that a less injurious alternative must be implemented.

The plaintiffs would have the court second-guess the decisions of the Medicaid policy makers and substitute its judgment of what would be a more desirable alternative. This the court refuses to do. The purpose of requiring state officials to consult with a Medicaid Medical Care Advisory Committee, constituted in accordance with applicable statutory and regulatory requirements, is to assure that the interests of Medicaid recipients will be taken into account in arriving at important policy and administrative decisions in regard to Medicaid. *See* Memorandum Opinion of September 3, 1980. Such consultation has apparently now been had in the present case, and absent some clear indication that the statutory guidelines have not been met, the court will defer to the policy decisions duly made.

[2] No such clear indication of statutory violation is present here. Rather, even if the court had accepted the plaintiffs' argument that the statistics on inpatient hospital usage for 1979-80

were representative of a general trend, and thus showed some likely disparate adverse impact on handicapped recipients, the evidence would still show that 95% of all handicapped recipients would be fully served with a 14-day-per-year limitation.[11] Thus the court would be constrained to hold that the evidence clearly established that the limitation was not in the best interests of recipients, especially where it is so abundantly clear, as it is here, that some cost savings measures must be taken if the Medicaid program is to continue to serve those in need. The facts of the case at bar simply do not provide a proper case for substitution of the court's judgment as to the most appropriate way to achieve the desired savings for that of the officials whose duty it is to make such decisions.[12]

Prior Approval of the Secretary of Health and Human Services

[3] The parties have stipulated that the proposal to reduce the inpatient hospital coverage from 20 to 14 days has not thus far been approved by the Secretary of Health and Human Services (HHS). Thus the court is presented with a purely legal question whether such approval is required prior to the implementation of such a change. The court concludes that prior approval is not required.

The argument advanced by the plaintiffs that prior approval is required is based upon the proposition that a state Medicaid plan must initially receive approval prior to federal funding of the state's program, 42 U.S.C. §1396, and the fact that HHS maintains oversight responsibility to assure that the state's plan remains in compliance with the statutory requirements. 42

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[11] *See* note 6, *supra*.

[12] It should be noted that the Secretary of Health and Human Services maintains continuing oversight responsibility for state plans, to ensure their continued compliance with the statutory requirements. *See* 42 U.S.C. §1396c. This oversight provides an additional safeguard that the interests of recipients will not be ignored in policy decisions.

U.S.C. §1396c; *National Welfare Rights Organization* v. *Finch*, 429 F.2d 725, 728 (D.C. Cir. 1970) (construing obligations under other titles of the Social Security Act). From these premises, the plaintiffs contend that it plainly follows that no alterations can be made in the approved state plan without prior approval.

The plaintiffs have characterized this argument as "the soul of simplicity." However, in reality it is the soul of over-simplification. Such a requirement would effectively hamstring the ability of state administrators to respond to changing demands on the Medicaid program or to respond to fiscal crises such as the one currently facing the State of Tennessee.

In addition, requiring prior approval of program changes does not square with certain express provisions of Title XIX. In relevant part, 42 U.S.C. §1396c provides as follows:

> If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds —
>
> (1) that the plan has been so changed it no longer complies with the provisions of section 1396a of this title;
>
> . . .
>
> . . .
>
> the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply.

This language clearly contemplates that the states do in fact have the latitude to modify their Medicaid plans, as long as such

modifications are in conformity with the statutory requirements. Congress could easily have provided that no state plan could be modified withotu prior approval of the Secretary, but instead authorized the Secretary to invoke sanctions when modifications were found to be out of compliance with the statute.

To read a requirement of prior approval into the statute would be to engage in legislation by judicial fiat, a practice this court is not wont to adopt. The result would be both to add a requirement which Congress has not seen fit to include, and to substantially obviate the need for 42 U.S.C. §1396c(1), *supra*. The court therefore holds that Title XIX does not require prior approval by the Secretary of HHS of modifications in the state Medicaid plan.[13]

Public Notice Requirements

Finally, the plaintiffs argue the the proposed reduction in inpatient hospital care must be enjoined because of the state's failure to comply with the public notice requirements of 42 C.F.R. §447.205. That regulation provides, in relevant part, as follows:

> (a) *When notice is required.* Except as specified in paragraph (b) of this section [not applicable in the case sub judice], the agency must provide public notice of any proposed change in the Statewide method or level of reimbursement for a service, if the change is expected to in-

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[13] This conclusion also appears wholly consistent with applicable regulations, which make express provision for prior approval in one situation only. Where a proposed change would alter the method of reimbursing hospitals for services provided, prior approval must be obtained. 42 C.F.R. §447.261(a). This specific provision coupled with the absence of similar regulations covering other types of changes leads to the conclusion that HHS does not view prior approval of most state plan modifications as mandatory.

crease or decrease Medicaid payments for that service by 1 percent or more during the 12 months following the effective date of the change.

. . . .

(c) *Content of notice.* The notice must —

(1) Describe the proposed change in method or level of reimbursement;

(2) Give an estimate of any expected increase or decrease in annual aggregate expenditures;

. . . .

(4) Identify a local agency in each county (such as the social services agency or health department) where copies of the proposed changes are available for public review;

(5) Give an address where written comments may be sent and reviewed by the public; . . . .

Such notice is further required to be published at least 60 days before the proposed effective date of the change and appear in both a state register and the newspaper of widest circulation in each city in the state with a population of 50,000 or more. 42 C.F.R. §447.205(d).

The salient facts concerning the public notice given in the present case are not disputed. On or about June 15, 1980, notice was published in the required newspapers outlining the changes under consideration, including the possible reduction in inpatient hospital benefits. This notice stated that the Tennessee Department of Public Health (DPH) intended, on August 15, 1980, "to make some or all" of the described changes in the Medicaid program. Interested persons were invited to write to the Commissioner of Public Health if they desired to comment

on the proposals.[14] In addition, the notice stated that copies of the exact proposed changes would be made available for inspection in all county offices of the Tennessee Department of Human Services (DHS) prior to August 1, 1980 (only two weeks before the proposed effective date of the changes).

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[14] Other parts of the notice outlined changes contemplated by the Comptroller of the Treasury and directed comments to that office. These proposals are not relevant here.

The proposed changes made available in county DHS offices on or about August 1, 1980, made no mention of the plan to reduce inpatient hospital coverage to 14 days per year. To the contrary, the notice posted in county DHS offices expressly stated that "[i]n-patient hospital services . . . will be limited to twenty days per fiscal year," and continued with a proposal to generally limt weekend hospital admissions to emergency cases.

Testimony offered by the defendants at the August 16, 1980, preliminary injunction hearing established at at the time the proposals were went to DHS offices, the state had no plans to make a reduction in inpatient hospital coverage. Rather, DPH at that time intended only to implement a penalty on hospitals with low occupancy rates as an alternative way to save state money. On August 11, 1980, however, DPH was advised by the Federal Department of Health and Human Services that such a penalty could not be imposed without prior HHS approval. *See* 42 C.F.R. §447.261(a), and discussion, *supra*. DPH therefore decided to reduce the number of inpatient hospital days rather than await HHS approval of the proposed penalty.

[4] The court finds that the state has failed to comply with the public notice requirements of 42 C.F.R. §447.205 in its failure to make the proposal to reduce inpatient hospital benefits available for public review in county DHS offices. In reaching this conclusion the court need not address the questionable propriety of delaying the posting of notice in county offices until two weeks before the proposed effective date of the changes. While the regulations are silent as to the timing of this particular requirement, the practical value of complying at such a late date would be dubious, at best. In the present case, however, there was simply no compliance whatsoever. The notice finally made available in county DHS offices did not include the proposal to limit inpatient hospital coverage to 14 days per year.

the contrary, that notice was affirmatively misleading in its statement that inpatient care would be limited to 20 days per year. A concerned Medicaid recipient who had been informed by the newspaper notices that a reduction in inpatient care might be implemented and who desired to learn exactly what changes were contemplated would surely have had his fears falsely allayed by the notice posted in his local DHS office. The only effect of this misinformation would certainly have been to discourage comment on the proposal which otherwise might have been forthcoming. The tactic was in direct contravention of the policy behind the notice requirement of "foster[ing] complete information to the public as to the cost of medical care to the needy." *Philadelphia Welfare Rights Organization* v. *O'Bannon,* 501 F.Supp. 517 (E.D.Penn.1979).

The fact that the plaintiffs offered no evidence that any Medicaid recipients ever actually relied upon the posted notice or ever attempted to comment on the proposed change is irrelevant. Likewise irrelevant are the facts that the state conducted hearings which were not required by federal law at which the proposed reduction in inpatient benefits were discussed and that the proposal was included in the notice published in the Tennessee Administrative Register.

The plain truth is that federal regulations establish a particular procedure for notifying the public exactly what changes in Medicaid reimbursement procedures are being considered. This procedure includes an opportunity to inspect the text of the proposals which are to be made available in county offices throughout the state. And the simple fact is that this procedure was not complied with. The court must therefore conclude that the prelimnary injunction previously issued preventing implementation of the proposed reduction of inpatient hospital benefits must be extended pending compliance with the public notice requirement sof 42 C.F.R. §447.205.

An appropriate order will be entered.

APPENDIX C

45 C.F.R. §§ 84.1—84.5

Subpart A—General Provisions

§ 84.1 Purpose.

The purpose of this part is to effectuate section 504 of the Rehabilitation Act of 1973, which is designed to eliminate discrimination on the basis of handicap in any program or activity receiving Federal financial assistance.

§ 84.2 Application.

This part applies to each recipient of Federal financial assistance from the Department of Health and Human Services and to each program or activity that receives or benefits from such assistance.

§ 84.3 Definitions.

As used in this part, the term:

(a) "The Act" means the Rehabilitation Act of 1973, Pub. L. 93-112, as amended by the Rehabilitation Act Amendments of 1974, Pub. L. 93-516, 29 U.S.C. 794.

(b) "Section 504" means section 504 of the Act.

(c) "Education of the Handicapped Act" means that statute as amended by the Education for all Handicapped Children Act of 1975, Pub. L. 94-142, 20 U.S.C. 1401 et seq.

(d) "Department" means the Department of Health and Human Services.

(e) "Director" means the Director of the Office for Civil Rights of the Department.

(f) "Recipient" means any state or its political subdivision, any instrumentality of a state or its political subdivision, any public or private agency, institution, organization, or other entity, or any person to which Federal financial assistance is extended directly or through another recipient, including any successor, assignee, or transferee of a recipient, but excluding the ultimate beneficiary of the assistance.

(g) "Applicant for assistance" means one who submits an application, request, or plan required to be approved by a Department official or by a recipient as a condition to becoming a recipient.

(h) "Federal financial assistance" means any grant, loan, contract (other than a proccurement contract or a contract of insurance or guaranty), or any other arrangement by which the Department provides or otherwise makes available assistance in the form of:

(1) Funds;

(2) Services of Federal personnel; or

(3) Real and personal property or any interest in or use of such property, including:

(i) Transfers or leases of such property for less than fair market value or for reduced consideration; and

(ii) Proceeds from a subsequent transfer or lease of such property if the Federal share of its fair market value is not returned to the Federal Government.

(i) "Facility" means all or any portion of buildings, structures, equipment, roads, walks, parking lots, or other real or personal property or interest in such property.

(j) "Handicapped person." (1) "Handicapped persons" means any person who (i) has a physical or mental impairment which substantially limits one or more major life activities, (ii)

has a record of such an impairment, or (iii) is regarded as having such an impairment.

(2) As used in paragraph (j)(1) of this section, the phrase:

(i) "Physical or mental impairment" means (A) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

(ii) "Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

(iii) "Has a record of such an impairment" means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

(iv) "Is regarded as having an impairment" means (A) has a physical or mental impairment that does not substantially limit major life activities but that is treated by a recipient as constituting such a limitation; (B) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or (C) has none of the impairments defined in paragraph (j)(2)(i) of this section but is treated by a recipient as having such an impairment.

(k) "Qualified handicapped person" means:

(1) With respect to employment, a handicapped person who, with reasonable accommodation, can perform the essential functions of the job in question;

(2) With respect to public preschool elementary, secondary, or adult educational services, a handicapped person (i) of an age during which nonhandicapped persons are provided such services, (ii) of any age during which it is mandatory under state-law to provide such services to handicapped persons, or (iii) to whom a state is required to provide a free appropriate public education under Section 612 of the Education of the Handicapped Act; and

(3) With respect to postsecondary and vocational education services, a handicapped person who meets the academic and technical standards requisite to admission or participation in the recipient's education program or activity;

(4) With respect to other services, a handicapped person who meets the essential eligibility requirements for the receipt of such services.

(l) "Handicap" means any condition or characteristic that renders a person a handicapped person as defined in paragraph (j) of this section.

§ 84.4 Discrimination prohibited.

(a) *General.* No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

(b) *Discriminatory actions prohibited.* (1) A recipient, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:

(i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;

(iv) Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing any aid, benefit, or service to beneficiaries of the recipients program;

(vi) Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

(vii) Otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.

(2) For purposes of this part, aids, benefits, and services, to be equally effective, are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons, but must afford handicapped persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement, in the most integrated setting appropriate to the person's needs.

(3) Despite the existence of separate or different programs or activities provided in accordance with this part, a recipient may not deny a qualified handicapped person the opportunity to participate in such programs or activities that are not separate or different.

(4) A recipient may not, directly or through contractual or other arrangements, utilize criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect to handicapped persons, or (iii) that perpetuate the discrimination of another recipient if both recipients are subject to common administrative control or are agencies of the same State.

(5) In determining the site or location of a facility, an applicant for assistance or a recipient may not make selections (i) that have the effect of excluding handicapped persons from, denying them the benefits of, or otherwise subjecting them to discrimination under any program or activity that receives or benefits from Federal financial assistance or(ii) that have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the program or activity with respect to handicapped persons.

(6) As used in this section, the aid, benefit, or service provided under a program or activity receiving or benefiting from Federal financial assistance includes any aid, benefit, or service provided in or through a facility that has been constructed, expanded, altered, leased or rented, or otherwise acquired, in whole or in part, with Federal financial assistance.

(c) *Programs limited by Federal law.* The exclusion of nonhandicapped persons from the benefits of a program limited by Federal statute or executive order to handicapped persons or the exclusion of a specific class of handicapped persons from a program limited by Federal statute or executive order to a different class of handicapped persons is not prohibited by this part.

§ 84.5 Assurances required.

(a) *Assurances.* An applicant for Federal financial assistance for a program or activity to which this part applies shall submit an assurance, on a form specified by the Director, tnat the program will be operated in compliance with this part. An applicant may incorporate these assurances by reference in subsequent applications to the Department.

(b) *Duration of obligation.* (1) In the case of Federal financial assistance extended in the form of real property or to provide real property or structures on the property the assurance will obligate the recipient or, in the case of a subsequent transfer, the transferee, for the period during which the real property or structures are used for the purpose for which Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits.

(2) In the case of Federal financial assistance extended to provide personal property, the assu.ance will obligate the recipient for the period during which it retains ownership or possession of the property.

(3) In all other cases the assurance will obligate the recipient for the period during which Federal financial assistance is extended.

(c) *Covenants.* (1) Where Federal financial assistance is provided in the form of real property or interest in the property from the Department, the instrument effecting or recording this transfer shall contain a covenant running with the land to assure non-discrimination for the period during which the real property is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits.

(2) Where no transfer of property is involved but property is purchased or improved with Federal financial assistance, the recipient shall agree to include the covenant described in

paragraph (b)(2) of this section in the instrument effecting or recording any subsequent transfer of the property.

(3) Where Federal financial assistance is provided in the form of real property or interest in the property from the Department, the covenant shall also include a condition coupled with a right to be reserved by the Department to revert title to the property in the event of a breach of the covenant. If a transferee of real property proposes to mortgage or otherwise encumber the real property as security for financing construction of new, or improvement of existing, facilities on the property for the purposes for which the property was transferred, the Director may, upon request of the transferee and if necessary to accomplish such financing and upon such conditions as he or she deems appropriate, agree to forbear the exercise of such right to revert title for so long as the lien of such mortgage or other encumbrance remains effective.

NO. 85-127

In the
Supreme Court of the United States
October Term, 1985

LAMAR ALEXANDER,
Governor of the State of Tennessee, et al.,

Petitioners,

v.

ROSIER JENNINGS, et al.,

Respondents.

ON A PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Is a "disparate impact, or "effects" test appropriate to determine a violation of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794) and regulations promulgated thereunder?

2. In the alternative, weighing all of the evidence of record, does such evidence establish that Tennessee's reduction of in-patient hospital coverage under its federally assisted Medicaid program has a disparate impact on the handicapped so as to establish a prima facie violation of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794) and regulations promulgated thereunder?

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OPINIONS BELOW

Since the printing of the Petition for a Writ of Certiorari, the August 4, 1983 opinion of the Sixth Circuit Court of Appeals has been published at 715 F.2d 1036. As noted in the Petition, the District Court decision is published at 518 F.Supp. 877. The text of both decisions were reproduced in the appendix to the Petition.

STATEMENT OF THE CASE

This case involves the legality of Tennessee's cutback in Medicaid coverage for hospital services to indigent handicapped patients. Although approximately 70% of the funds for the Medicaid program are provided by the federal government, Tennessee administers the program and defines the scope of eligibility and coverage within limits prescribed by Title XIX of the Social Security Act, 42 U.S.C. §1396a et seq., and other applicable federal laws and regulations. Title XIX specifically requires the State to provide in-patient hospitalization to patients covered by its Medicaid program. 42 U.S.C. §1396a(a)(13).

In August, 1980, in an effort to reduce its Medicaid expenditures, the State proposed sweeping cutbacks in services covered by the program. Tennessee Medicaid patients filed the present action on August 14, 1980 challenging on procedural and substantive grounds the legality of several of the specific reductions. By the time the District Court reached a final decision on the merits on June 17, 1981, all but one of these challenges had been settled.

The remaining issue, which is now before this Court, involves a reduction in the number of days of annual hospital coverage from 20 to 14. While conceding the broad latitude enjoyed by the State in reducing the coverage of the Medicaid program, plaintiffs [respondents here] challenged the particular method chosen by defendant state officials [petitioners here]. The reduction in in-patient hospital coverage was challenged inter alia, because of its sharply discriminatory impact on the handicapped. At issue is whether such discrimination is prohibited by Section 504 of the Rehabilitation Act of 1973 and accompanying regulations, which prohibit discrimination against the handicapped in federally assisted activities. 29 U.S.C. §794; 45 C.F.R. §84.

At trial, the evidence established without contradiction that Tennessee's handicapped Medicaid patients, who are by definition destitute, have extremely limited access to needed hospital care in the absence of available Medicaid coverage. It was also proven without dispute that the effect of the State's reduction in hospital coverage would be to limit Medicaid patients' access to hospital services. This effect would be felt most heavily by the handicapped. Indeed, undisputed statistics showed that handicapped patients would be nearly four times as likely as non-handicapped patients to be denied hospital care as a result of the cutback. 518 F.Supp. 877, at 881; Petition for a Writ of Certiorari, Appendix [hereafter "P.A."] at A-32.

State officials admitted that they had not given any thought to the impact of the cutback on the handicapped or any other group of Medicaid patients. They were concerned instead with meeting the objections of the hospital industry, which had protested their original plan to realize the necessary cost savings by the adoption of tightened hospital reimbursement policies. These reimbursement restrictions, although consistent with Title XIX, would have required the prior approval of the Secretary of Health, Education and Welfare. That factor, and a desire to be responsive to hospital industry objections, were the only considerations or alternatives taken into account when state officials hastily settled upon the reduction in hospital coverage. 715 F.2d at 1044; P.A. at A-14.

Plaintiffs presented further evidence that an alternative method of calculating hospital benefits was available which would achieve the same cost-savings without as great an impact on handicapped patients' access to medical care.[1/]

[1/] Although it is of no analytical significance, in order to avoid any confusion it should be noted that the Sixth Circuit opinion mistates the alternative proposed by the plaintiffs. The Court of Appeals refers to the alternative under consideration as a limit on the total number of hospital visits per year, rather than on the number of days of in-patient coverage. 715 F.2d at 1044; P.A. at A-13. Actually, the alternative which was the subject of plaintiffs' proof in the trial court would limit the number of days of hospital coverage on a per-stay basis, without any limit on the number of stays per year. See 518 F.Supp. at 883 n.7; P.A. at A-36 n.7.

The District Court concluded that there had not been sufficient evidence to support a finding of disparate impact on the handicapped. 518 F.Supp. 877 (M.D.Tenn., 1980); P.A. at A-27. The trial court concluded further that, even if the evidence were deemed sufficient to establish a disparate impact, such discrimination is not of the type proscribed by Section 504.

On August 4, 1983, ruling on an appeal brought by the plaintiffs, the Sixth Circuit Court of Appeals vacated and remanded the case for further proceedings. 715 F.2d 1036; P.A. at A-1. The appellate court emphasized the broad latitude enjoyed by the State in fashioning the coverage of its Medicaid program. The Circuit Court rejected plaintiffs' procedural objections to the cutback, as well as their substantive argument that the method selected violated the State's duty under 42 U.S.C. §1391a(a)(19) to administer the program in "the best interests of recipients". The Court of Appeals concluded, however, that the plaintiffs had indeed succeeded in proving the cutback's disparate impact on handicapped patients' access to hospital care. The opinion noted that even the defendants had conceded as much in their brief before that court. 715 F.2d at 1042 n.7; P.A. at A-11 n.7. This showing was held sufficient to establish a prima facie case under Section 504. The case was then remanded to afford the defendants another opportunity to offer a substantial justification for their actions.

One member of the Sixth Circuit panel, Judge Merritt, dissented from the remand decision. Relying in part on analogous cases under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et seq., he expressed doubt as to whether a "disparate impact" test is the appropriate measure by which to assess compliance with Section 504. 715 F.2d at 1049; P.A. at A-25. The dissenting opinion also asserted that the majority based its finding of discrimination on the State's failure to engage in

"affirmative action" necessary to afford handicapped patients "equality of results", rather than mere equality of access. 715 F.2d at 1048; P.A. at A-23-24.

The majority countered that criticism by pointing out that it had made no "finding of discrimination" whatever, much less a finding based on an application of an "affirmative action" test. The majority reiterated that all it had decided was what elements of proof are sufficient to establish a prima facie case, thereby triggering a further inquiry by the trial court. Expressly disavowing any intimation of its view regarding the ultimate outcome of the litigation, the panel remanded the case to the District Court for further proceedings. 715 F.2d at 1046 n.12; P.A. at A-19. There, the majority emphasized, defendants may yet defeat the plaintiffs' claim by establishing that their actions were substantially justified notwithstanding the concededly disparate impact of these actions upon the handicapped. 715 F.2d at 1044-1045; P.A. at A-15-16.

Defendants have petitioned this Court for certiorari to review the decision of the Sixth Circuit to remand the case to the trial court for further development of the record and final disposition.

REASONS FOR DENYING THE WRIT

This case is not in a proper posture for review by the Supreme Court. The petition for certiorari is premature. The petition also represents an inappropriate effort to litigate in this Court issues which were either conceded or simply not raised at all in the lower court.

Even if the case were in a posture appropriate for review, neither of the questions raised in the petition would warrant consideration by this Court.

A. This case is not ripe for review by this Court.

This case is not ripe for review in its present posture. The lower courts have yet to make their decision on the merits of the case, nor have they even finished developing the record necessary to reach such a determination. In the absence of such a record, the Sixth Circuit has explicitly refused to intimate any view regarding the proper or probable outcome of the lawsuit. 715 F.2d at 1046 n. 12; P.A. at A-19 n.12. It is noteworthy that all but one of the numerous issues which were initially litigated were mooted out or settled as the case moved through the District Court. One such issue was settled after it had been tried and submitted to the trial judge. 715 F.2d at 1039-1040; P.A. at A-2, A-3. That experience attests to the prudence of withholding premature review of what is yet an undeveloped issue.

B. The petition for certiorari raises issues which petitioners either conceded or simply failed to raise at all in the lower courts.

Neither of the questions presented for review was squarely addressed in the lower courts. From the outset of the litigation, the state conceded as a factual matter the existence of a disparate impact. In neither the trial nor

appellate court did the state question the validity of the disparate impact test or the federal regulations mandating the application of such a test. Prior to seeking review from this Court the petitioners limited themselves simply to arguing that, as a matter of regulatory and statutory construction, the type of disparate impact which they conceded to be present did not fall within the "disparate impact" standard to be applied under Section 504.

In a startling reversal of field, the petitioners now challenge for the first time the "disparate impact" standard itself and, by implication, the federal regulations which prescribe that standard. 45 C.F.R. §84.4; P.A. at A-55 - A-57. Were certiorari to be granted on that question, this Court would be forced to review a question which had not been briefed, argued or directly addressed in either of the courts below.

As their second issue for review, petitioners question whether the facts in this case demonstrate a disparate impact on the handicapped. The petitioners explicitly conceded this issue below. In the district court, the state's own expert witness, a biostatistician, concluded that handicapped patients utilized the inpatient hospital services at issue "at a much higher level than the non-handicapped Medicaid recipients." Court of Appeals Joint Appendix, p. JA-207. In the face of that and other overwhelming evidence, the petitioners conceded below the factual issues they would resurrect here. In their brief before the Sixth Circuit, petitioners stated candidly:

> "The statistics and studies were computed and analyzed by the parties in several different ways during the course of the trial. Suffice it to say, the studies indicated that the handicapped population of Medicaid recipients would suffer proportionately more from the reduction in hospital benefits than the non-handicapped Medicaid recipients."
>
> 715 F.2d at 1042 n.7; P.A. at A-11 n.7.

C. In any event, the questions presented in the petition for certiorari do not warrant consideration by this Court.

1. This Court should not be used for the litigation of factual issues.

Petitioners' question as to whether the evidence establishes disparate impact raises an issue of fact. This Court should not be used for the relitigation of factual issues. The use of this forum for that purpose is particularly inappropriate where, as in the present case, the factual issue raised by the petitioners was conceded by them in the lower courts.

2. The Court of Appeals' legal ruling creates no conflict with the decisions of other Circuits or this Court.

The petitioners seek review of a Sixth Circuit legal ruling which quite simply does not exist. The petitioners contend that the Court of Appeals found a violation of Section 504, when in fact that court only found that the plaintiffs had made out a prima facie case, thus necessitating a remand for further proceedings in the trial court. Petitioners therefore mistakenly equate the elements of a prima facie case with the elements of a final finding of illegal discrimination. Hence petitioners' assertion that the Sixth Circuit has mandated "affirmative action" or "equality of results" under Section 504.

The Sixth Circuit itself renounces the construction imputed to its decision by the petitioners, emphasizing that it has dealt only with the elements of a prima facie case, and nothing more. 715 F.2d at 1046 n.12; P.A. at A-19 n.12. Indeed, the Sixth Circuit explicitly countenances a finding of nonviolation of Section 504 even in situations where there is a striking disparity of access. The Court of Appeals does so by allowing petitioners an opportunity to show that their apparently discriminatory actions are nonetheless substantially justified and, therefore, lawful.

The petitioners attempt to infer from their mistaken reading of the Sixth Circuit decision a conflict with the decisions of other Circuits and this Court. The petitioners are unable to cite any decisions from other Circuits which squarely conflict with the Sixth Circuit's ruling. They contend, however, that the ruling is unprecendented, so much so that it is described as opening the courts to a whole new type of litigation.

Read as it is written, rather than as petitioners describe it, the Sixth Circuit ruling is neither unprecedented nor broad. The disparate impact test which the Sixth Circuit applies is established in the federal regulations promulgated by the Secretary of Health and Human Services. 45 C.F.R. §84.4; P.A. at A-55. It has been applied by other Circuits. NAACP v. The Medical Center, Inc., 657 F.2d 1322 (3rd Cir., 1981)(en banc); Prewitt v. United States Postal Service, 662 F.2d 292 (5th Cir., Unit A, 1981). Petitioners have cited no cases, and there are no cases of which respondents are aware, in which any other Court of Appeals has declared the regulations invalid or refused to apply the tests which they embody. The other Circuits have no quarrel with the Sixth Circuit's ruling on the elements of a prima facie case under Section 504.

Neither is there any conflict between the Sixth Circuit's ruling and the decisions of this Court. Indeed, the petitioners' attack on the "disparate impact" test under the Section 504 regulations amounts to a plea that this Court reconsider its decision in Guardians Association v. Civil Service Commission of New York, U.S. , 103 S.Ct. 3221, L.Ed.2d (1983). Whatever the broader implications or applicability of Guardians to Section 504 litigation, at a minimum it supports the decision of the Sixth Circuit in this case. The Sixth Circuit, following the lead of the other Circuits cited above, has held that the effects test

promulgated in the Secretary's regulations should be applied to private plaintiffs' claims for prospective relief under Section 504.

Once the petition's mistaken characterization of the Court of Appeals' ruling is corrected, the spectre conjured by the petitioners disappears. The decision does not create a whole new source of litigation that will wreak havoc with the State's budgetary decisions. This point is amply illustrated in cases cited in the certiorari petition itself. In both NAACP v. The Medical Center, Inc., supra, 657 F.2d 1322 and Bryan v. Koch, 627 F.2d 612 (2nd Cir., 1980) plaintiffs challenged the relocation or closure of hospitals on the grounds that the curtailment of care rendered by those facilities would have an adverse disparate impact on minorities and/or the handicapped. In both cases, the plaintiffs succeeded in proving a disparate impact on a protected group. In each case the court assumed that such proof was sufficient to establish a prima facie case, and that consideration of other potentially less onerous alternatives was therefore appropriate. Yet in both cases the plaintiffs ultimately lost because the defendants succeeded in showing that their selection of the apparently discriminatory alternative was justified. In short, the broad impact which the petitioners attribute to the Sixth Circuit's ruling has failed to materialize in the wake of similar rulings by other courts.

CONCLUSION

For the foregoing reasons, the respondents respectfully request that the Petition for Writ of Certiorari be denied.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on this 30th day of November, 1983, a copy of Respondents' Brief in Opposition was served on counsel for all parties required to be served by depositing same in a United States mailbox, with first class postage prepaid, addressed to William B. Hubbard, Chief Deputy Attorney General, State of Tennessee, 450 James Robertson Parkway, Nashville, TN 37219.

G. Gordon Bonnyman, Jr.

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FILED
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ALEXANDER L. STEVAS
CLERK

(4)

No. 83-727

IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

LAMAR ALEXANDER, GOVERNOR OF THE STATE OF TENNESSEE, *et al.*,
Petitioners,

vs.

ROSIER JENNINGS, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

JOINT APPENDIX

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Petition for Certiorari granted February 21, 1984

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

DOCKET ENTRIES

Documents and Entries	Date
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Answer of the Defendants Fowinkle and Crim in Their Individual Capacities ..... October 17, 1980

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

COMPLAINT - CLASS ACTION

Preliminary Statement

This is a class action brought by and on behalf of Tennessee Medicaid recipients for declaratory and injunctive relief from reductions in services which the Tennessee Department of Public Health plans to implement on August 15, 1980. If the proposed reduction in outpatient hospital visits from thirty (30) per year to six (6) per year, the proposed restriction on drugs covered under the Medicaid formulary and the proposed freeze on Medicaid formulary and the proposed freeze on Medicaid beds in intermediate care facilities are implemented by The Department of Public Health, the plaintiffs will suffer irreparable harm to their health that no amount of money will compensate nor any amount of remedial health care will correct. If the proposed physician reimbursement rate is implemented, a number of private physicians will drop out of the Medicaid program and many Medicaid recipients will have no doctor to provide their basic medical services.

Plaintiffs challenge the proposed reductions in services on the grounds that they conflict with Title XIX of the Social Security

Act. The proposed reductions (a) will result in the Medicaid program's failure to provide medical services in sufficient amount, duration, and scope to reasonably achieve their purpose; (b) bear no relation to medical necessity; and (c) discriminate on the basis of diagnosis or treatment. The plaintiffs maintain that by proposing and implementing these reductions the defendants have denied benefits to handicapped persons in violation of the Rehabilitation Act of 1973 and the defendants have discriminated against racial minorities in violaiton of the Civil Rights Act of 1964. Plaintiffs further maintain that the intentional proposal of racially discriminatory service reductions by defendants Fowinkle and Crim violation the Equal Protection Clause of the United States Constitution.

Plaintiffs challenge the procedural implementation of the reductions on the ground that the defendants' failure to consult the Tennessee Medicaid Medical Advisory Committee and failure to provide adequate notice of the reductions to recipients are in violation of federal law and regulations. Further, plaintiffs maintain that the defendants' failure to provide adequate notice and opportunity for hearing prior to implementation of the reductions in services violates their constitutional right to due process of law.

Plaintiffs face irreparable injury and harm for which there is no adequate remedy at law. Plaintiffs, therefore, seek a temporary restraining order and a preliminary injunction, in addition to appropriate declaratory relief.

Jurisdiction

1. The court is vested with jurisdiction in this case by 28 U.S.C. § 1343(3) and (4), which provide for original jurisdiction in all suits arising under 42 U.S.C. § 1983. Jurisdiction is also conferred pursuant to 28 U.S.C. § 1331 which grants jurisdiction in matters arising under the Constitution and laws of the United States. The Medicaid coverage at stake for each named Medicaid plaintiff and each member of the plaintiff class exceeds $10,000.

2. Plaintiffs' request for declaratory and injunctive relief is authorized by 42 U.S.C. § 1983, 42 U.S.C. § 2000d, 28 U.S.C. § 2201 and § 2202 and Rule 57 of The Federal Rules of Civil Procedure.

Parties

3. Plaintiffs Rosier Jennings, Herschel Choate, Wilma Ann Hyder, Clyde Vaughn, Eldon Kerr, Stella Harris, Sadie Owens, Margaret Betty Baldwin, Charles Baldwin, and Carrie Clemmons are all adult citizens of the United States, residents of Tennessee and Medicaid recipients.

4. Paul Ramone Parsons, Michelle Ogle, Rebecca West, Mary Baldwin and Charles Baldwin are minors who are residents of Tennessee and recipients of Medicaid. These children, along with Rosier Jennings and Clyde Vaughn who are incompetent, bring this action by next friends as stated in the caption.

5. Defendant Lamar Alexander is the Governor of the State of Tennessee, and, as such, is vested with the Supreme Executive Power of the State by Article III, Section 1 of the Constitution of Tennessee. Defendant Alexander is responsible for the administration of State government, including administration of the Medicaid program. 45 C.F.R. §201.3(a) requires that the Governor be consulted before any amendments are made in the Medicaid plan. The Governor is also responsible for establishing a Medical Care Advisory Committee, a committee which advises The Department of Public Health on the Medicaid program. *Tenn. Code Ann.* § 14-23-120. Defendant Alexander is sued in his official capacity.

6. Defendant Eugene Fowinkle is the Commissioner of the State of Tennessee Department of Public Health and, as commissioner, is charged with the overall responsibility for the administration of the State's Medicaid program. His duties include adopting and implementing policies that conform to applicable federal laws and regulations. Defendant Fowinkle is

sued both individually and in his official capacity as Commissioner.

7. Defendant Ben Crim is Assistant Commissioner of the Department of Public Health, and is charged with administration and coordination of the Medicaid program. Defendants Fowinkle and Crim are sued both in their official capacities and as individuals.

8. Defendant Carolyn Hale is the Director of the Cumberland County Department of Human Services. Under a federally approved contractual arrangement with The Deparment of Public Health, the Department of Human Services is responsible for conducting fair hearings on grievances pertaining to the Medicaid program. Each county director is responsible for assuring that hearings are provided and conducted in compliance with federal law. Defendant Hale is sued in her official capacity and as a representative of all Department of Human Services County Directors.

Class Action Allegations

9. Pursuant to Rule 23 of the Federal Rules of Civil Procedure the named plaintiffs bring this suit on behalf of themselves and the class of all Tennessee Medicaid recipients. In addition, this class contains three subclasses.

a. Plaintiffs Harris and Clemmons represent a subclass of Medicaid recipients who are members of a racial minority.

b. Plaintiffs Jennings, Owens, Ogle, West and Parsons represent a subclass of handicapped Medicaid recipients.

c. Plaintiff Mary Baldwin represents a subclass of Medicaid recipients who received no notice of the proposed reductions in the Medicaid program.

10. The pre-requisites of Rule 23(a) are met for the class and its subclasses in that:

(a) The class has so many members that joinder of all members is impracticable; upon information and belief. There are more than 300,000 Medicaid recipients in the State of Tennessee.

(1) Upon information and belief, there are more than 150,000 Medicaid recipients who are members of a racial minority.

(2) Upon information and belief, there are thousands of handicapped Medicaid recipients in the State of Tennessee.

(3) Upon information and belief there are at least 200 Medicaid recipients who received no notice of the impending cutbacks because they were wrongfully terminated from Medicaid for a brief period of time.

(b) There are questions of law or fact common to all members of the class. These questions include: Whether Medicaid recipients are being unlawfully denied adequate notice and an opportunity for a hearing before reduction of Medicaid benefits? Whether Medicaid recipients are being denied Medicaid coverage sufficient in amount and scope to achieve its purpose? Whether Medicaid recipients are being discriminated against on the basis of diagnosis?

(1) In addition the subclass of all racial minority Medicaid recipients raises common questions of law which include: Whether minority recipients are being unlawfully discriminated against by the reductions in outpatient services and the restrictions on the formulary?

(2) In addition the subclass of all handicapped Medicaid recipients raises the common questions of:

Whether handicapped individuals are being unlawfully discriminated against on the basis of their handicaps by the reductions in out-patient care, the restrictions on the formulary and the freeze on Medicaid funded beds in intermediate care facilities?

(c) The claims of the named plaintiffs are typical of the claims of the class. All Tennessee Medicaid recipients are entitled to adequate notice and opportunity for hearing. All Tennessee Medicaid recipients are entitled to Medical services which are sufficient in amount and scope to reasonably achieve their purposes.

(1) The claims of the named plaintiffs in their subclass of racial minority Medicaid recipients are typical of the claims of their subclass. All minority Medicaid recipients are entitled to receive the same medical services as other Medicaid recipients.

(2) Additionally the claims of the named plaintiffs in the subclass of handicapped individuals are typical of the claims of the class. All handicapped Medicaid recipients are entitled to receive Medicaid services equivalent to services received by non-handicapped individuals.

(d) The named plaintiffs will fairly and adequately protect the interests of the class. The named plaintiffs have a sharply drawn, personally vital controversy with the defendant which dictate that they will fully and vigorously prosecute this action. At stake for all of the named plaintiffs is a continuation of or improvement of their current health status and for some of the named plaintiffs even have their lives at stake. The plaintiffs are represented by non-profit legal services organizations experienced in class action litigation. The relief sought for the individual plaintiffs is identical with the relief sought for the class as a whole.

11. Plaintiffs seek certification of the class under the provisions of Rule 23(b) (1) in that the prosecution of separate actions by individual members of the class would create a risk of inconsistent or varying adjudications which would establish incompatible standards of conduct for the party opposing the class and would as a practical matter be dispositive of the interests of other members not party to the adjudication.

12. Plaintiffs also seek certification of the class under the provisions of Rule 23(b)(2) in that the defendants' action to terminate services will generally affect the entire class of medicaid recipients in reducing Medicaid services as will be defendants failure to implement the reductions in services in compliance with federal law.

Statutory and Regulatory Scheme

13. The purpose of the Medicaid program is to provide assistance to eligible individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396.

14. The Medicaid program is funded and administered through cooperation of the federal and state governments, pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq*. The program provides certain necessary medical services to certain categorically eligible and indigent persons. States such as Tennessee which choose to participate in the Medicaid program must comply with the requirements of Title XIX and regulations promulgated under the authority of Title XIX by the United States Department of Health and Human Services. A state wishing to establish a Medicaid program must submit a state plan for medical assistance which provides that the state will meet the requirements of federal law. 42 U.S.C. § 1396.

15. A state participating in the Medicaid program is required to provide Medicaid to persons receiving Aid to Families with Dependant Children (AFDC). A state must elect to provide

Medicaid to one of several other categories of persons and Tennessee has elected a category including, among others, all persons receiving Supplemental Security Income (SSI) benefits. 42 U.S.C. § 1396(a)(10)(A).

16. A state may provide Medicaid coverage for other needy individuals, and Tennessee has elected to provide partial coverage for individuals who are categorically eligible for AFDC or SSI benefits but whose income is too high for them to receive these benefits. These individuals are termed "medically needy" or "exceptionally medically needy". 42 U.S.C. § 1396(a)(10)(C).

17. In order for the state to receive federal funds, the state must offer certain required medical assistance services, including certain inpatient hospital services, outpatient hospital services, laboratory and x-ray services, skilled nursing facility services, early and periodic screening, diagnosis, and treatment services of children under 21, family planning services and supplies, and physician services. 42 U.S.C. § 1396(a)(13)(B).

18. In addition a state may elect, as Tennessee has done, to cover other enumerated types of services for which federal reimbursement is available. Included among these "optional" services which Tennessee has elected to provide are home health services, clinic services and prescribed drugs.

19. Pursuant to 42 U.S.C. § 1396c, the Tennessee Department of Public Health has contracted with the Social Security Administration to make determinations of Medicaid eligiblity on behalf for individuals receiving or eligible for Supplemental Security Income benefits.

20. Pursuant to 42 U.S.C. § 1396a(a)(5) the Tennessee Department of Public Health has contracted with the Tennessee Department of Human Services (DHS) to make determinations of Medicaid eligiblity on its behalf for individuals who are receiving or eligible for Aid to Families with Dependent

Children. The contract also provides that the Department of Human Services will be responsible for conducting fair hearings on grievances pertaining to Medicaid eligibility and entitlement.

21. DPH has also contracted with Electronic Data Services Federal Corporation (EDSF) to process claims for Medicaid coverage.

Factual Allegations

1. Impending Cutbacks

22. On or about July 1, 1980, some Medicaid recipients received notices of proposed reductions in services covered by Medicaid and a general notice that payments to some Medicaid providers would be reduced. (See Attachment A) Although these notices did not specify which reductions would be made in the Medicaid program, among other things, they indicated the formulary might be restricted, the prescriptions Medicaid would pay for monthly might be reduced, hospital outpatient visits might be significantly reduced except in hardship circumstances and the number of Medicaid reimbursed beds in intermediate care facilities might be reduced.

23. The notices to Medicaid recipients did not specify which drugs would be deleted from the formulary. Although the notices indicated exceptions would be made in hardship cases for outpatient hospital care, no guidelines were given on qualifications for the hardship exception. Upon information and belief the Tennessee Department of Public Health has no published standards for determining qualifications for hardship circumstances or procedures for prior approval.

24. Upon information and belief the readability level of the July 1, 1980 notices to recipients is above the eleventh grade level and the average educational attainment of Medicaid recipients in Tennessee is at the eighth grade level.

25. The Medicaid recipient notices did not explain the circumstances under which a hearing would be granted if requested and an explanation of the circumstances under which Medicaid would be continued if a hearing was requested.

26. The notice of reduction in Medicaid benefits was not received by plaintiff Margaret Betty Baldwin and the class of Medicaid recipients she represents. Upon information and belief, the notices of Medicaid reductions were not sent to an entire class of Medicaid recipients, including, but not limited to, approximately two hundred (200) Medicaid recipients who were wrongfully terminated from the Medicaid program for a brief period of time.

27. On July 28, 1980, the Tennessee Department of Public Health mailed exact proposed rule changes to county offices of the Tennessee Department of Human Services. (Attached as Exhibit C) Upon information and belief, these are the changes that will be implemented in the Medicaid program. Upon information and belief, Medicaid recipients have received no notice of these exact changes.

28. The Tennessee Medicaid Medical Advisory Committee is authorized by *Tenn. Code Ann.*, 14-23-120, and members of that committee are appointed by the Governor of the State of Tennessee. Upon information and belief there are presently no consumers and no members of racial minorities on that committee.

29. Upon information and belief, a meeting of the Tennessee Medicaid Medical Advisory Committee has not been convened at any time during calendar year 1980. Nor has the Medicaid Medical Advisory Committee been consulted about the reductions in the Medicaid program.

30. The racially discriminatory effect of defendants' proposed reduction of services and reimbursement are striking and are well known to the defendants. The *Tennessee Department of*

Public Health, Statistical Report on Medical Care: Recipients, Payments and Services, Fiscal Year 1978 (1/4/79) shows that in the existing Medicaid program for every dollar spent on white Medicaid recipients, only 53 cents is spent on minority recipients, despite the fact that the health status of blacks is generally poorer than that of whites.

31. The state's proposed cutback in hospital outpatient services exacerbates rather than rectifies these striking inequities. In attempting to cut Medicaid expenditures, Tennessee has targeted one of the few services in which a disproportionate share of Medicaid funds is spent meeting the needs of black patients. For although blacks receive only 29.95 per cent of all Medicaid funds, 56 per cent of the Medicaid dollars spent on outpatient hospital services are provided to minority patients. Of the black share of Medicaid funds 7.55 per cent is spent for the purchase of outpatient hospital services, but only 2.53 per cent of the white share of Medicaid funds is spent for outpatient services. This greater dependence by blacks on outpatient hospital services is related to well documented occurrences of chronic diseases in the black population. The traditional patterns of discrimination in access to private health care by blacks, fostered in part by official state action, also accounts for the greater dependence by minorities on outpatient hospital services.

32. Upon information and belief a numnber of categories of medically necessary drugs will be deleted from the Medicaid formulary and will no longer be available for Tennessee Medicaid recipients. (See Attachment B) For example, these formulary deletions will have a significant impact on all pre-natal women, children with iron-deficiency anemia, epileptics and older people with chronic respiratory problems.

33. Upon information and belief, the proposed restrictions in the formulary will have a discriminatory impact on racial minorities. For example, the proposed formulary deletes all

vitamins, including pre-natal vitamin supplements. In its impact on maternal and infant mortality and morbidity, this aspect of the state's plan complements the intended curtailment of pre-natal outpatient care. The correlation between low birth weight ratios stemming from poor pre-natal nutrition, and the racially disparate frequency of infant mortality is well documented. In Tennessee, 1977 statistics show that black infants with low birth weights are twice as numerous as white infants with low birth weights.

34. Upon information and belief, the reduction in physician reimbursement rates will result in decreased physician participation in the Medicaid program leaving many Medicaid recipients without private physicians.

35. Upon information and belief, the ceiling on Medicaid reimbursed nursing home beds will in effect freeze the number of beds funded by Medicaid at the present level in no relation to the number of people who need those beds.

II. **Named Plaintiffs**

36. Rosier Jennings is a seventy-seven (77) year old stroke victim who has been bedridden for nine (9) years, and has a medical history of high blood pressure and of recurring bronchitis. Mr. Jennings' physician prescribes cough and cold medications for the treatment of bronchitis and to prevent Mr. Jennings' frequent colds from causing him pneumonia, and also prescribes potassium to replace that depleted from Mr. Jennings' body as a side effect of the drugs he uses to control his hypertension. Upon information and belief, the proposed revisions in the Medicaid formulary would deny coverage of these essential medications. Mr. Jennings and his wife, Kathleen Jennings, reside in Jamestown, Tennessee. Their entire income is from Social Security benefits and Supplemental Security Income. Mrs. Jennings, with the help of home health services, has faithfully cared for Mr. Jennings. If his precarious physical condition worsens in any way, she will no longer be able to care for

him at home and will have to admit him into an Intermediate Care Facility. Yet, the availability of such treatment will be jeopardized by the impending freeze on the number of beds covered by Medicaid.

37. Hershel Choate, of Jamestown, Tennessee, receives Supplemental Security Income as a result of his total disability due to epilepsy. To control his epilepsy, Mr. Choate's physician has prescribed three drugs: dilantin, phenobarbitol, and valium. The valium tablets, which on information and belief are to be deleted from the Medicaid formulary, are prescribed both as an adjunct to his other prescriptions and as a preventative measure to decrease the likelihood of seizures.

38. Wilma Ann Hyder, a resident of Crossville, Tennessee, has had uncontrollable diabetes for a 21 year period. Social Security determined Ms. Hyder to be completely and permanently disabled eight years ago after she had a suprapubic cystotony requiring the insertion of a tube in her stomach. This tube requires continual maintenance and is a constant source of urinary tract infections. Ms. Hyder has other multi-system disorders resulting from her diabetes and is now almost totally blind. To relieve pain from neuropathy, and in hopes that it can control her neuropathy, Ms. Hyder's physician prescribes biweekly injections of Vitamin B-12, a vitamin which will be deleted from the formulary. Ms. Hyder also sees a psychiatrist monthly at the Cumberland Medical Center outpatient clinic. Ms. Hyder receives Medicaid through the medically needy spend down program, since she spends more than $200 monthly for her medical care.

39. Clyde Vaughn, a resident of Crossville, Tennessee, is a fifty-seven (57) year old male with multiple medical problems. Mr. Vaughn has respiratory problems, gastrointestinal problems and a brain tumor. Mr. Vaughn is frequently a hospital inpatient. In addition, Mr. Vaughn must use the hospital emergency room on weekends. Mr. Vaughn's doctors presently

prescribe nine (9) drugs for his medical condition. If the formulary restrictions are implemented, Mr. Vaughn will not be able to get all of his drugs.

40. Paul Ramone Parsons is a fourteen (14) year old resident of Crossville, Tennessee, who suffers from ostaochondramatosis, a hereditary bone disease. This bone disease causes tumors to grow on Paul's bones and surgery is required to remove them. Since Paul's condition was discovered twelve years ago, he has had extensive surgery. After surgery, Paul is extremely susceptible to bone fractures. This bone condition has caused Paul's bones to grow improperly. Last year Paul was admitted to the emergency room at Cumberland Medical Center eight (8) times. Many of these visits occurred shortly after surgery and some visits were the result of accidents. Paul's condition makes it very probable that he will need emergency room services this year in excess of the two uses allowed by the proposed reductions in services.

41. Rebecca West is a six (6) year old victim of cerebral palsy who resides in Cleveland, Tennessee. She receives physical therapy at a hospital outpatient unit several times a month, and last year she exceeded the thirty (30) day visit limit then in effect. Her mother has been advised that, without faithful adherence to the therapy regime, Rebecca will never be able to walk.

42. Michelle Ogle is a nine and a half (9 1/2) year old child residing with her mother in Cleveland, Tennessee. Michelle is quadriplegic, totally blind, and suffers profound psycho motor retardation. She spent two months within the past year in an intermediate care nursing home, and is frequently hospitalized. Due to her low resistance to disease, she sees her physician on an average of five times per month and has been admitted to a hospital emergency room from eight to ten times in the past year, frequently for pneumonia. She receives several prescription drugs as well as gamma globin.

43. Eldon Kerr is a thirty-eight (38) year old SSI recipient who is a hemophiliac, has epilepsy, peptic ulcers and is missing a leg. He has been hospitalized for much of his life and must make frequent visits to the emergency room because of his medical condition.

44. Stella Harris is a thirty-nine (39) year old black female with sickle cell anemia who receives Supplemental Security Income. In addition to requiring hospitalization, her condition makes her dependent upon frequent treatments as a hospital outpatient. Ms. Harris resides in Chattanooga, Tennessee.

45. Sadie I Owens, of Fayetteville, Tennessee, is a paraplegic victim of multiple schlerosis and other medical problems. Despite her handicap, she cares for her three children who live with her. Last year she was hospitalized in excess of the present twenty (20) days of inpatient Medicaid coverage and used the hospital emergency room on two occasions. Because of the progressive nature of Ms. Owens' illness, she may well need emergency room treatment this year in excess of the proposed emergency room limitations.

46. Margaret Betty Baldwin, a resident of Nashville, Tennessee, is a thirty-nine (39) year old permanently and totally disabled woman who is receiving Supplemental Security Income, making her automatically eligible for Medicaid. She suffers from a chronic bladder infection, a nervous disorder, chest disease with congestion, migraine headaches and sinus trouble. Her doctor recently dropped out of the Medicaid program after state officials began to discuss cutbacks. Despite the fact that she lives in an urban area served by a large number of physicians, nearly all of them refuse to participate in the Medicaid program and she has been unable to find a physician who accepts Medicaid patients and will treat her. Ms. Baldwin must go for outpatient treatment at a hospital clinic in Nashville every six weeks but will soon exhaust her Medicaid coverage for such visits if the cutback is implemented. If the restricted drug for-

mulary goes into effect, Ms. Baldwin will be unable to obtain medications prescribed for the control of her bladder infection and nervous disorder.

47. Ms. Baldwin's husband, Charles, is forty-nine (49) years old and also disabled. He received medical treatment at the same hospital clinic attended by Ms. Baldwin. If the restricted drug formulary goes into effect, Mr. Baldwin will not be able to obtain necessary medications prescribed by his physicians.

48. The Baldwins' daughter, Mary, age thirteen (13), has three medical problems: epilepsy, asthma, and severe psorasis. The Social Security Administration has found her to be disabled, primarily as a result of her psorasis.

49. The Baldwins' grandons, Charles, age seventeen (17) months, has epilepsy and an acute iron deficiency anemia. He must visit outpatient hospital facilities in excess of twenty times a year. If the limitation on outpatient visits goes into effect Charles will be unable to obtain necessary medical treatment. If the restricted drug formulary goes into effect Charles will no longer be able to obtain medication prescribed for the treatment of his anemia. The condition will become more severe and he will not develop properly. Charles' medical are so severe that they have already caused the loss or part of his tongue.

50. Carrie Clemmons, a resident of Nashville, Tennessee, is a forty-six (46) year old black woman who is totally disabled, subsisting on Supplemental Security Income and Social Security. She has diabetes, hypertension, seizure disorders, heart disease, sinus trouble, phlebitis and a nervous disorder. Since July 1, 1980, Ms. Clemmons has been to the emergency room on three occasions thereby exceeding the proposed limitation of two emergency visits per year. If the restricted drug formulary goes into effect Ms. Clemmons will not be able to obtain two of the medications prescribed for her by her doctors.

51. If the proposed changes in the Medicaid program go into effect the plaintiffs and the class of Medicaid recipients they

represent will suffer irreparable harm to their health no amount of money will compensate nor any amount of remedial health care will correct. The types of injury and harm demonstrated in the personal circumstances of the named plaintiffs epitomize the kinds of injuries which will be sustained by members of the plaintiff class as a whole as a result of the impending withdrawal of necessary medical services. Plaintiffs have no adequate remedy at law.

First Cause of Action

52. In order to receive federal funds under the Medicaid program, each state must establish standards and methods to assure the delivery of high quality care. 42 U.S.C. § 1396a (22)(D). The federal regulations require each state to establish a Medical Care Advisory Committee whose members must be selected from certain enumerated interest groups. 42 C.F.R. § 431.12(d) The Medical Care Advisory Committee (MCAC) must include "members of consumers' groups, including Title XIX recipients, and consumer organizations . . ."

53. The present composition and selection mechanisms of the Medicaid Medical Advisory Committee violate Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d *et seq.* and 28 C.F.R. § 42.104(d)(1) and (2), and the requirement that the MCAC contain representatives of consumers, including Title XIX recipients, and of consumers groups, 42 C.F.R. § 431.12(d)(2).

Second Cause of Action

54. The Medical Care Advisory Committee, once constituted, is to "have opportunity for participation in policy development and program administration, including furthering the participation of recipient members in the agency program." 42 C.F.R. § 431.12(e).

55. The defendants have refused or failed to consult a properly constituted Medical Care Advisory Committee prior to the final decision to reduce Medicaid services and provider reimburse-

ment, in violation of 42 U.S.C. § 1396a(a)(22)(I) and 42 C.F.R. § 431.12(e).

Third Cause of Action

56. The state agency administering the Medicaid program is required to give advance notice to Medicaid recipients of any action to reduce Medicaid services. The notice required must contain:

> "(a) a statement of what action the agency intends to take;
>
> '(b) the reasons for the intended action;
>
> '(c) the specific regulations that support, or the change in federal or state law that requires, the action;
>
> '(d) an explanation of (1) the individual's right to request an evidentiary hearing if one is available, or a state agency hearing; or (2) in cases of an action based on a change of law, the circumstances under which a hearing will be granted; and
>
> '(e) an explanation of the circumstances under which Medicaid is continued if a hearing is requested."

42 C.F.R. § 431.20

57. The defendants have refused or failed to provid Medicaid recipients with adequate notice of the exact changes in services covered by the program, to provide recipients with notice of their right to a fair hearing and continued assistance pending that hearing, and an opportunity for such a hearing, in violation of 42 U.S.C. § 1396(a)(3), 42 C.F.R. § 431.206, 42 C.F.R. § 431.220 and in violation of plaintiffs' right to due process of law as guaranteed by the Fourteenth Amendment to the United States Constitution.

Fourth Cause of Action

58. The defendants have restricted the number of outpatient hospital visits, a service used much more by racial minorities

than by whites and removed drugs from the Medicaid formulary which disparately impact on minority Medicaid recipients in violation of 42 U.S.C. § 2000d *et seq.* and 45 C.F.R. § 80.1 *et seq.* which prohibit discrimination in programs receiving federal financial assistance.

Fifth Cause of Action

59. The defendants have restricted the number of outpatient hospital visits, eliminated drugs from the Medicaid formulary and frozen the number of reimbursed Medicaid beds in intermediate care facilities in violation of 42 U.S.C. § 1396a and 42 C.F.R. §§ 440.230(b) and (c)(2) which require that services be provided under the state plan in sufficient amount, duration, and scope to reasonably achieve their purpose, and which provide that services may appropriately be limited based on medical necessity or utilization control procedures.

Sixth Cause of Action

60. The defendants have reduced physician reimbursement rates to such an extent that the Tennessee Medicaid program is in violation of 42 C.F.R. § 447.204, which mandates that physician reimbursement rates under the state plan shall be formulated so as to encourage availability of medical services to Medicaid recipients comparable to availability of those services to the general public, and 42 C.F.R. § 440.230(b) which requires that each service be available in sufficient amount to reasonably achieve its purpose.

Seventh Cause of Action

61. The defendants deletion of drugs from the Medicaid formulary which are particularly needed by persons with handicapping conditions, the defendants restriction of outpatient hospital visits for therapy and defendants freeze on Medicaid reimbursed beds in intermediate care facilities are in violation of § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, which prohibit discrimination against handicapped individuals in any program which receives federal financial assistance.

Eighth Cause of Action

62. The defendants deletion of drugs from the Medicaid formularly which are needed by persons with particular diseases, their restriction of outpatient hospital visits which are necessary to persons with certain conditions and their restriction in Medicaid reimbursed beds in intermediate care facilities are in violation of 42 U.S.C. § 1396a and 42 C.F.R. § 440.230(c)(1) which prohibit denial or reduction of services based on diagnosis, type of illness or condition.

Ninth Cause of Action

63. Defendants Fowinkle and Crim have violated the right of racial minority recipients to equal protection of law in violation of the Fourteenth Amendment of the United States Constitution by intent and effect in proposing and implementing discriminatory reductions in Medicaid benefits.

Relief Requested

WHEREFORE, plaintiffs, individually and on behalf of their class, request that the Court grant the following relief:

1. Assume jurisdiction of this cause, certify the plaintiff class and maintain continuing jurisdiction until the rights of the parties are finally determined.

2. Grant a temporary restraining order restraining defendants, their agents, employees and successors in office, and all other persons in active concert and participation with them, from implementing the proposed reductions in the Medicaid program on August 15, 1980.

3. Declare that the defendants have violated the rights of the plaintiffs under 42 U.S.C. § 1396a, 29 U.S.C. §794, 42 U.S.C. § 2000d *et seq.* and the Due Process Clause of the Fourteenth Amendment to the Constitution of the United States.

4. Declare that defendants Fowinkle and Crim have violated plaintiffs' rights under the Equal Protection Clause of the Fourteenth Amendment to the Constitution of the United States.

5. Preliminarily and permanently enjoin defendants from implementing the proposed reductions in the Medicaid program contained herein or from otherwise violating 42 U.S.C. § 1396a, 42 U.S.C. §2000 d *et seq.*, 29 U.S.C. § 794 and the Due Process and Equal Protection Clauses of the Fourteenth Amendment of the Constitution of the United States.

6. Provide reasonable attorneys fees as authorized by 42 U.S.C. § 1988 and 29 U.S.C. § 794a.

7. Grant plaintiffs such other relief as may be necessary and appropriate to serve their rights.

Respectfully submitted,

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Counsel for Plaintiffs

IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

AMENDED COMPLAINT

Plaintiffs, pursuant to Rule 15(a) of the Federal Rules of Civil Procedure, amend their complaint by adding to the section entitled "Factual Allegations: I. Impending Cutbacks" the following paragraphs, to follow paragraph 35 and precede paragraph 36 of the original complaint:

35. (a). According to the affidavit of James E. Word, Deputy Commissioner of the Tennessee Department of Public Health, filed in this action on August 14, 1980, defendants will, effective August 16, 1980, reduce the number of inpatient hospital days covered by Medicaid from a current level of twenty days per fiscal year to a limit of fourteen days per calendar year. Defendants' intended policy makes no allowance for the medical necessity of inpatient hospital services being deleted from the Medicaid program. The defendants' proposed reduction in Medicaid coverage of inpatient hospital services was not included in the public notice posted in County offices of the Tennessee Department of Human Services (Attachment "C" to the original verified complaint) which notices

were incorporated in the legal notices published throughout the state on or about June 15, 1980. (Attached as Collective Exhibit "D" to the affidavit of James E. Word). The inpatient hospital days which are being deleted from Tennessee's Medicaid program are medically necessary, and the loss of such treatment will result in irreparable injury to the health and safety of members of the plaintiff class, many of whom have already exhausted their coverage for the current calendar year.

35. (b). The Tennessee state Medicaid plan required by 42 U.S.C. §§1396, 1396a, 1396b and 1396c has not, according to the affidavit of James E. Word, filed by the defendants August 14, 1980, been amended to reflect the changes in the amount, scope and duration of services and levels of provider reimbursement intended by the defendnats and challenged by plaintiffs herein. Tennessee's approved state Medicaid plan does not authorize the Medicaid cutbacks which the defendants intend to implement August 16, 1980.

Plaintiffs further amend the causes of action contained in the original complaint in the following manner:

1. The fifth cause of action, paragraph 59, is amended to add the following sentence: "The defendants' reduction of the number of inpatient hospital days covered by the Tennessee Medicaid program violates 42 U.S.C. 1396a and 42 C.F.R. §§440.230(b) and (c)(2), which require that services provided under the state plan be sufficient in amount, duration, and scope to reasonably achieve their purpose, and which provide that services may only be limited on the basis of medical necessity or utilization control procedures."

3. The eighth cause of action, paragraph 62, is amended to add the following sentences: "The defendants'

reduction of the number of inpatient hospital days covered by the Medicaid program discriminates against persons with certain conditions, in violation of 42 U.S.C. §1396a and 42 C.F.R. §440.230 (c)(1), which prohibit denial or reduction of services based on diagnosis, type of illness or condition."

4. A tenth cause of action, paragraph 64, is hereby added to the complaint and reads as follows:

64. Defendants' reduction of the amount, scope and duration of services, and of levels of provider reimbursement, provided under the Tennessee Medicaid program places the state's administration of the Medicaid program in conflict with its existing approved state Medicaid plan. The changes which defendants intend to implement have not been incorporated in state Medicaid plan amendments which have been fully reviewed by the Secretary of Health and Human Services and approved by her following a determination of their conformity with federal law and policy. Defendants' intended cutbacks in the Tennessee Medicaid Program therefore violate 42 U.S.C. §1396 and 1396c as well as 42 C.F.R. §205.5(a).

5. An eleventh cause of action, paragraph 65, is hereby added to the complaint and reads as follows:

65. Defendants' reduction of Medicaid coverage for inpatient hospital services, in conflict with prior public notices affirmatively representing that no such cutbacks would be made, violated 42 C.F.R. §447.205.

Plaintiffs further amend that section of their original complaint which is captioned "Relief Requested" by deleting paragraphs three and five of that section (page 23 of the complaint) and substituting therefore the following paragraphs:

3. Declare that the defendants have violated the rights of the plaintiffs under 42 U.S.C. §§1396 et seq., 29 U.S.C. §794, 42 U.S.C. §2000d et seq., and federal regulations promulgated pursuant to these statutes, and the Fourteenth Amendment to the Constitution of the United States.

4. ...

5. Preliminarily and permanently enjoin defendants from implementing the proposed reductions in the Medicaid program complained of herein, or any other reductions prior to review and approval by the Secretary of an amendment to the state Medicaid plan, or from otherwise violating 42 U.S.C. §1396, et seq., 42 U.S.C. §2000d et seq., 29 U.S.C. §794, and federal regulations promulgated pursuant to these statutes, as well as the due process and equal protection clauses of the Fourteenth Amendment of the Constitution of the United States.

The remainder of the original complaint not explicitly deleted herein, is hereby incorporated herein by reference as fully as if set forth verbatim.

Respectfully submitted,

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COUNSEL FOR PLAINTIFFS

(CERTIFICATE OF SERVICE OMITTED IN PRINTING)

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

ANSWER OF THE DEFENDANTS LAMAR ALEXANDER, GOVERNOR OF THE STATE OF TENNESSEE, EUGENE W. FOWINKLE, M.D., IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF THE DEPARTMENT OF PUBLIC HEALTH AND BEN CRIM, IN HIS OFFICIAL CAPACITY AS ASSISTANT COMMISSIONER OF THE DEPARTMENT OF PUBLIC HEALTH

Defendants Alexander, Fowinkle and Crim in their official capacities, respond to the original and amended complaint of the plaintiffs, paragraph by paragraph, as follows:

1. *First Sentence.* Admitted.

   Second Sentence. Admitted.

   Third Sentence. Admitted.

2. Admitted.

3. *First Sentence.* Denied.
Second Sentence. Denied.

Third Sentence. Admitted.

Fourth Sentence. Denied. The Governor of the State of Tennessee is responsible only for appointing members of the Medical Care Advisory Committee. The establishment and composition of the committee is the responsibility of the Commissioner of the Tennessee Department of Public Health.

4. Admitted.

5. Admitted.

6. Admitted.

7. Admitted.

8. *First Sentence.* Admitted.

Second Sentence. Admitted to the extent that the Department of Human Services is responsible for conducting fair hearings on grievances pertaining to Medicaid "eligibility."

Third Sentence. Admitted to the extent that each county director is responsible for assuring that hearings are provided with respect to Medicaid "eligiblity."

Fourth Sentence. Admitted.

9. Plaintiffs admit that the defendants seek class action certification as stated in paragraph 9 but deny that said class certification is appropriate.

10. Defendants deny that plaintiffs have met the prerequisites for class certification as set forth in paragraph 10.

11. Denied. The relief that plaintiffs seek in their complaint can be granted by the Court irrespective of whether the class certification requested by plaintiffs is granted.

12. Denied.

13. Admitted.

14. Admitted.

15. Admitted.

16. Admitted.

17. Admitted.

18. Defendants admit the allegations contained in paragraph 18 and, in addition, state that the intermediate care nursing home services are also an "optional" service of the Medicaid program.

19. Admitted.

20. Admitted.

21. Admitted to the extent that "claims for Medicaid coverage" constitute claims for services submitted by medical care providers who have rendered service to Medicaid recipients.

22. *First Sentence.* Defendants admit that on or about July 1, 1980 the notice set out in Attachment A was sent to all of the approximately 300,000 Medicaid recipients in the State of Tennessee.

Second Sentence. Admitted.

23. *First Sentence.* Admitted.

Second Sentence. Admitted.

Third Sentence. Admitted.

24. The defendants are without knowledge or information sufficient to form a belief as to the truth or validity of the allegations contained in paragraph 24.

25. Admitted.

26. *First Sentence.* The defendants are without knowledge or information sufficient to form a belief as to whether Margaret Betty Baldwin in fact received the notice attached to plaintiffs' complaint as Attachment A.

Second Sentence. Denied.

27. *First Sentence.* Defendants admit that on or about July 28, 1980 the Tennessee Department of Public Health mailed proposed rule changes to county offices of the Tennessee Department of Human Services which are set out in Exhibit C to plaintiffs' complaint.

Second Sentence. Admitted.

Third Sentence. Denied.

28. *First Sentence.* Admitted.

Second Sentence. Denied.

29. *First Sentence.* Admitted.

Second Sentence. Denied.

30. *First Sentence.* The defendants deny that the proposed reductions in services and levels of reimbursement racially discriminate against the defendants or the class which they proportedly represent.

Second Sentence. The defendants admit that the statistical report cited in the second sentence of paragraph 30 accurately reflects money spent by the Medicaid program during the fiscal year 1978. The defendants are unable to admit or deny the ambiguous allegation that the "health status of blacks is generally poorer that that of whites" without further specificity as to the meaning plaintiffs give this phrase.

31. *First Sentence.* Denied.

Second Sentence. Denied.

Third Sentence. Defendants are unable to answer the third sentence of paragraph 31 in that plaintiffs fail to state for which time period said percentages apply.

Fourth Sentence. Defendants are unable to answer the fourth sentence to paragraph 31 in that plaintiffs fail to state for which time period said percentages apply.

Fifth Sentence. Denied.

Sixth Sentence. Denied.

32. *First Sentence.* Defendants admit that certain drugs heretofore available under the Medicaid program will be deleted under proposed reductions.

Second Sentence. Denied.

33. *First Sentence.* Denied.

Second Sentence. Denied.

Third Sentence. Denied.

Fourth Sentence. Defendants are unable to answer the fourth sentence of paragraph 33 in that plaintiffs fail to state the source of statistical conclusions drawn.

Fifth Sentence. Defendants are unable to respond to the fifth sentence of paragraph 33 in that plaintiffs fail to cite the precise statistics mentioned.

34. Denied.

35. Denied.

36 - 50. The defendants admit that all the named individuals in paragraphs 36-50 are presently eligible for Medicaid benefits and have in the past received said benefits. The only manner in which the defendants can respond to the allegations regarding

the medical conditions of the individual plaintiffs and their required medical care, is to determine what services have been rendered to them under the Medicaid program. This can only be done by retrieving such data from the computer system of EDS Federal Corporation as to claims submitted by providers of plaintiffs medical care. The defendants at the present time are in the process of retrieving said data and upon completion thereof will answer paragraphs 36-50. At the present time, however, the defendants are without knowledge or information sufficient to form a belief as to the truth or validity of all the allegations contained in paragraphs 36-50.

51. Denied.

52. *First Sentence.* Admitted.

Second Sentence. Admitted.

Third Sentence. Admitted.

53. Denied.

54. Admitted.

55. Denied.

56. Admitted.

57. Denied.

58. Denied.

59. Denied.

60. Denied.

61. Denied.

62. Denied.

63. Denied.

The defendants further respond to plaintiffs' first amended complaint, paragraph by paragraph, as follows:

35(a). *First Sentence.* Admitted.

Second Sentence. Denied.

Third Sentence. Admitted.

Fourth Sentence. Admitted.

Fifth Sentence. Denied.

35(b). Defendants admit that the presently approved Medicaid plan does not reflect the proposed reductions. Said proposed changes, however, have been formally submitted to the U.S. Department of Health and Human Services in accordance with procedures established and followed by the Department since Tennessee first participated in the Medicaid program in 1969.

59. *Additional Sentence.* Denied.

61. *Additional Sentence.* Denied.

62. *Additional Sentence.* Denied.

64. *(A New Paragraph).* Denied.

65. *(A New Paragraph).* Denied.

WHEREFORE, the aforementioned named defendants in their official capacity, having fully responded to plaintiffs' complaint, respectfully request that said complaint be dismissed and that judgment be rendered in their favor.

Respectfully submitted,

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(CERTIFICATE OF SERVICE OMITTED IN PRINTING)

IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

No. 80-2043-NE-CV

Rosier Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, et al.,
Defendants.

STIPULATION OF FACTS

Counsel for the parties in this cause hereby stipulates that the following facts are true and need not be proven at trial:

1. Since August 15, 1980, defendants have given individual written notice to all providers and recipients of Medicaid services that previously announced reductions in the Tennessee Medicaid program have been suspended and will not be implemented pending further notice. No contrary notice has been published in any newspaper of general circulation or forwarded to either providers or recipients, since August 15, 1980.

2. Prior to implementing any reduction in the amount, scope or duration of services to be covered by the Tennessee Medicaid program, the defendants will send to all Tennessee Medicaid recipients individual written notices specifying which cuts are to take effect, and specifying the hearing rights, if any, which recipients may have to challenge the intended reductions.

3. The defendants have not received either written or oral federal approval of proposed state Medicaid plan amendments incorporating the Medicaid reductions which are the subject of this litigation.

The Office for Civil Rights for the Department of Health and Human Services (OCR) is currently reviewing the proposed

amendments for their compliance with *inter alia*, Section 504 of the Rehabilitation Act of 1973, and regulations promulgated thereunder. OCR, in furtherance of this review has submitted to the defendants a request for certain data pertaining to the impact on handicapped recipients of the proposed Medicaid cutbacks. The defendants have provided part, but not all, of the information sought by OCR as a basis for determination of the proposed state plan amendments compliance with Section 504.

4. On January 30, 1981, the Tennessee Medical Care Advisory Committee (MCAC) completed its review of the proposed cuts in the Tennessee Medicaid program. The committee recommended against implementation of some formulary reductions, and against a reduction in the number of covered days of inpatient hospital care. The defendants have received and considered the Committee's written reports and recommendations.

5. The parties stipulate that the affidavits filed by the parties in support of, or in opposition to, the granting of preliminary injunctive relief shall, with the exception of affidavits of expert medical witnesses whose depositions are offered in evidence, be received as evidence in the trial of this case. The parties further stipulate to the qualification as expert witnesses of all licensed physicians giving oral or affidavit testimony in this case.

6. Defendants have proposed to delete several hundred drugs from the formulary of prescription medications provided to eligible receipients under Tennessee's Medicaid program. Of these proposed deletions, plaintiffs challenge only the proposal to delete Medicaid coverage of the following drugs for any use:

a. Oral hematinics

b. Oral anti-histamines

c. Benzodyazapines

7. A reduction of Medicaid coverage of inpatient hospital days from twenty (20) to fourteen (14) days per year would result in a savings of approximately ten percent (10%) of that portion of the Medicaid budget attributable to inpatient services.

8. All figures used or developed by the defendants to measure the impact of the proposed Medicaid cutbacks upon handicapped patients have defined as "handicapped" only those patients who have been determined to be "blind" or "disabled" within the meaning of 42 U.S.C. §1382c(a)(2),(3) which defines eligibility for Supplemental Security Income (SSI) benefits under the Social Security Act. The parties further stipulate that SSI recipients are classified as "aged" whether or not they are blind or disabled when they reach the age of sixty-five.

9. Due to the reporting practices of hospital providers, there is no information available to the parties regarding the relative rates of utilization of exactly twenty days of inpatient hospital services by handicapped versus non-handicapped Medicaid patients. (The statistical data available to, and maintained by, the defendants lumps users of twenty (20) days of hospital care together with all users of any amount in excess of twenty days.) However, the parties do not have any information that would indicate that patterns of patient utilization of twenty days coverage per year differ significantly from patterns of utilization of fifteen to nineteen (15-19) days of hospitalization per year.

10. In connection with the defendants' weighing of alternative methods of reducing the cost of the Tennessee Medicaid program, Tennessee Medicaid personnel generated no memoranda, reports or other written information pertaining to methods used by other states to control Medicaid costs without compromising program services.

DATED this 16th day of February, 1981.

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IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

No. 80-2043-NE-CV

Rosier Jennings, et al.,

Plaintiffs,

v.

Lamar Alexander et al.,

Defendants.

SUPPLEMENTAL STIPULATION OF FACTS

Counsel for the parties in this cause hereby supplement the stipulation of facts entered into on February 16, 1981 and agree that the following facts are true and need not be proven at trial.

12. The Tennessee Department of Human Services is responsible for enforcement of Section 504 of the Rehabilitation Act of 1973 with regard to the receipt, investigation, disposition and compilation of complaints from Medicaid recipients alleging discrimination against the handicapped in connection with the administration of Tennessee's Medicaid program. Such complaints are commingled by the Department of Human Services and filed with all other unrelated Medicaid recipient requests for administrative review of program decisions or practices. Recipient requests for administrative review on all matters, including discrimination allegations, total several thousand per year. Allegations of Section 504 violations are not separately indexed. For this reason, retrieval and review of recipient complaints of discrimination, though possible, are not feasible.

13. The defendants have not performed any written self-evaluations of their compliance with Section 504 of the Rehabilitation Act of 1973 in their administration of the Tennessee Medicaid program.

(Signatures of counsel omitted in printing.)

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his next friend, Kathleen Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor, State of Tennessee, et al.,
Defendants.

**PRELIMINARY INJUNCTION HEARING,
AUGUST 15, 1980**

TESTIMONY OF JAMES E. WORD

[Transcript of Proceedings, pp. 63-65, 90-91 and 97-98]

Direct Examination

By Mr. Scanlon:

Q. Mr. Word, you are a deputy commissioner of the Tennessee Department of Public Health; is that correct?

A. That is correct.

Q. How long have you been employed by the Department of Public Health?

A. July, 1969, eleven years.

Q. What was one of the major reasons you were first employed by the Tennessee Department of Public Health in 1969?

A. Commissioner Fowinkle employed me in 1969 with one of the major purposes to implement the Tennessee Medicaid Program.

Q. Since 1969, have you had general oversight and responsibility for the Medicaid program in the state of Tennessee?

A. Yes, I have.

Q. Mr. Word, just a few preliminary things before we get into the exact changes in the program. There has been a lot of discussion about there being cuts and cut-backs in the Medicaid program. Is the budget for this coming fiscal year for the Tennessee Medicaid Program, is that more or less money that had been spent on the program last year?

A. The Legislature has authorized for program services, and nursing home care, $388 million dollars, $26 million dollars above what was authorized last year for the program services and nursing home care.

Q. What is the reason that we are at the position where certain changes, reductions in program services, have to be made in level of reimbursement, since there was an increase in funding by the General Assembly, why are we still in the position to make these changes?

A. The Medicaid program, if it were to be continued at the 1979-80 level, in the area of program services and nursing home care was projected to cost the state and federal government, projected cost, $430 million dollars. It was the determination during the budget process by the executive branch and the legislative branch that $388 million dollars would be authorized. So it was incumbent upon the department to limit the growth of Medicaid to the $26 million dollars plus $42 million dollars which would have been to carry it to 1979-80 level or $68 million dollars.

Q. Mr. Word, when you first came to the state of Tennessee, what was the budgeted Medicaid program for the first year of its operation, do you recall?

A. As I recall roughly for the first year of Medicaid, we implemented, I believe, in October of 1969, the first year expenditures were $17 million dollars.

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Q. Mr. Word, the final areas of the cut-backs in the program that I wish to discuss is the hospital in-patient days. Is hospital in-patient care required under the Medicaid program?

A. Yes, it is.

Q. Now, prior to the change to be effective tomorrow, how many days per year did the Medicaid program pay recipients for hospital care?

A. We paid for between, and I might add as an aside, Judge, your question awhile ago on how we arrived at that, the number 20 again was a subjective number chosen in 1969, and it's been 20 ever since 1969.

Q. You are reducing now to 14, is that correct?

A. Yes, that is our intent.

Q. Do you have any idea—I believe you gave a figure up here a little while ago, Your Honor, with respect to percentage of impact and Mr. Word corrected me. I'll ask the question now. Have you arrived at any kind of ideas what impact this will have on Medicaid recipients by going back 14 days as opposed to 20?

A. If we pay for 14 days of in-patient hospitalization, we'll pay for the number of hospital days that are required by 90 percent of the recipients.

Q. Is this for a particular year you did this?

A. This is for fiscal year 1978-79.

Q. Are you saying then that in that year 90 percent of the Medicaid recipients used 14 days or less on the program, is that correct?

A. That is correct.

Q. During that year they could have gone to 20, is that correct?

A. That is correct.

Q. They didn't use them all up?

A. Right. And it's our opinion that again meets the federal requirement of amount, duration and scope.

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Q. Am I correct that you made a decision sometime before August 1st not to reduce the number of in-hospital days?

A. At the time we issued the original public notice, we had not made a decision. A tentative decision was made before August 1st that it would not be necessary to reduce in-patient hospital days in order to get the forty-eight and a half million dollars. We were advised on August 1st that in fact we could not make the change in the method of reimbursement to hospitals. Later in that week we did—well, really, later in this week, we did reconsider whether or not we were going to reduce from 20 to 14 days, and there was a decision to reduce it.

Q. But am I correct, is it a fair statement that you all decided you weren't going to do that, and the Atlanta office of HEW told you you couldn't put that cut into effect without prior approval?

A. Which cut are you referring to?

Q. The cut in hospital reimbursement.

A. The reduction method?

Q. Yes.

A. The Atlanta office, on August 1st, in a letter from Richard Morris, advised us we had to have prior approval. That's all

they advised. Had to be prior approval before it could be implemented.

Q. Am I correct the only thing at that point you had submitted to Atlanta was, in writing, was a request to approve the change?

A. We had submitted nothing to Atlanta in writing at that point.

Q. What prompted that letter from Mr. Morris?

A. You'll have to ask Mr. Morris that question.

Q. You were at that point it was the letter from Mr. Morris, though, that prompted your decision to go to the hospital inpatient day limitation on coverage?

A. That, and during the public hearing, we were repeatedly hearing from the—at least from providers that they would rather have the number of days reduced than they would to tamper with the method. Those two things, yes, did prompt that decision.

Q. Anything else that prompted that decision other than what you outlined?

A. Not that I know of.

Q. You at no time received any approval from Atlanta to implement these proposed reductions?

A. We have at no time received—we have at no time received any approval or denial. We did not submit it until August 13th, and we had no communication....

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EVIDENTIARY HEARING, FEBRUARY 17, 1981

TESTIMONY OF ELEANORE MOORES

[Transcript of Proceedings, pp. 10-25]

Direct Examination

By Miss Garner:

Q. Miss Moores, I'm going to read a statement that summarizes your background information and I'd like you to listen to it carefully and tell me if it is correct.

You reside at 3416 Murphy Road, Nashville, Tennessee. Are a social worker on the staff of Veterans Administration Hospital in Nashville. You'll be testifying today as an individual and not in connection with the VA Hospital. You received a Bachelor of Science Degree in sociology and psychology and have a Master of Social Work Degree, certified by the National Association of Social Workers.

Your employment experience has included a position with the Department of Mental Health in Alabama, Medical Outpatient Clinic, Vanderbilt Hospital, and Kidney Dialysis and Transplantation, Vanderbilt Hospital, and Veterans Administration Hospital. Your responsibilities as social worker

have been to obtain admission for patients without ability to pay, particularly kidney dialysis and transplant patients.

As a social worker at Vanderbilt Hospital from September, 1977, until October, 1979, you had opportunity to observe the hospital admission practices, and the difficulties encountered by indigent and Medicaid-eligible patients in securing admission to the hospital; is that correct?

A. That is correct.

Q. Miss Moores, please describe the policy and practice of Vanderbilt Hospital as you observed it with respect to persons unable to pay for hospital care.

THE COURT: Now, a little something there. She's connected with Veterans Administration Hospital by an arrangement between Veterans Administration and Vanderbilt; is that correct?

WITNESS: I was formerly an employee of Vanderbilt Hospital.

THE COURT: For how long?

WITNESS: Two years.

THE COURT: What was this time limit?

WITNESS: September of '77 until the end of October, '79.

THE COURT: September of '77? All right. Thank you. Go ahead.

Q. (Miss Garner) Miss Moores, go ahead and describe the policy and practice of Vanderbilt Hospital as you observed it with respect to persons unable to pay for hospital care at Vanderbilt.

MR. SCANLON: Your Honor, I'd like to make clarification of the testimony here. The witness, I take it, is not testifying about the present practice?

THE COURT: She's testifying about '77 through '79, that's all she knows, unless she says she knows something different later on.

MR. SCANLON: Thank you, Your Honor.

THE COURT: Have to give the breakdown at that time.

WITNESS: Okay. The policy at the time I was employed at Vanderbilt was they did not turn away emergency admissions. This created a problem with, particularly with some of the kidney patients that we worked with who had no resources, because people with renal failure who will go on kidney machine, their condition will not ever go away, get well, but they continue to deteriorate. There comes a point in that time when a person is not technically an emergency, but when it's necessary that they come to the hospital for needed treatment, hopefully to prevent their ever becoming an emergency.

On more than one occasion we encountered the situation where a patient had absolutely no resources for hospitalization, and they had to be allowed to remain where they were, and deteriorate to emergency status before they could receive the needed medical care. We had one patient who went through this process twice. What this boils down to is that instead of a proposed and timely hospitalization of seven to eight days for initiation of dialysis, when these patients became emergencies, they then spent approximately thirty days in the hospital, the first five, six or seven of which were in intensive care, which is a more expensive proposition both in terms of money and the patient's well-being.

Q. (Miss Garner) Miss Moores, at the time you worked at Vanderbilt Hospital with the kidney dialysis and transplant patients, were there other facilities where they could get the necessary treatment for the kidney conditions?

A. Vanderbilt is a center as described under provisions of Medicare, and is the only center in Nashville. Peritoneal dialysis

is available at General. Hemodialysis, and peritoneal dialysis are both available at Vanderbilt. However, since it is a center, many people came from even other states or as far away as Knoxville in our state.

THE COURT: That is another state.

WITNESS: So that some of these patients would not have been eligible for admission to General, and General did not have the whole range of services available.

Q. Miss Moores, you described situations where a person's condition would be permitted to deteriorate until they were emergency patient and could be admitted to Vanderbilt. Did you ever see that phenomenon occur with persons who had exhausted their Medicaid coverage and therefore were not admitted to the hospital?

A. Yes, I did. The patient in particular that I referred to that went through this process twice was a person who when she became an emergency the first time, was admitted to Vanderbilt, and because of the expenses she was incurring at that time she qualified for the Medicaid spindown program which gives twenty days of hospitalization. She was in the hospital thirty days, and so she exhausted her entire year's allotment during that hospitalization and had ten days left over.

Then when she became an emergency again, there was no place to turn, because she had already exhausted her Medicaid, and so she had to allow—had to be allowed to become an emergency before she could be admitted to the hospital the second time.

Q. Mrs. Moores, during the time you worked at Vanderbilt, did you keep any documentation of these crises?

A. Only during one brief period when I was—I was so frustrated in trying to arrange hospitalization for patients like this who kept cropping up, and who had no resources, and over

the period, August 1st of '78 to about January of '79, I documented five patients, but there were six instances because one of these was the one I referred to this happened to twice. The purpose of gathering this data, these data, was to try to influence the policy at Vanderbilt in hopes that some arrangement could be made to admit these patients before they became emergencies.

Q. Were you successful in influencing administration policies of Vanderbilt Hospital?

A. No, I was not. In all fairness let me say that in going through the chain of command, my recommendations, I don't think, ever got out of my department. So I'm not sure that the arguments that I put forth ever reached decision makers at Vanderbilt.

Q. At the time you left Vanderbilt Hospital, these policies were as you stated they were here?

A. Right.

Q. Was the policy that you have described at Vanderbilt Hospital an across-the-board policy for all admissions to the hospital or did it pertain only to kidney patients you described?

A. Vanderbilt's policy across the board is they never turn away emergencies.

Q. Therefore, the phenomena that you described would occur in all instances; is that correct?

A. That could happen in many different cases, yes.

Q. When you were working at the medical outpatient clinic at Vanderbilt, did you observe the same phenomena?

A. We had some difficulty getting patients admitted for needed admissions at that time, too.

Q. What was Vanderbilt's policy and practice with respect to Medicaid recipients whose coverage was exhausted after they had been admitted and treatment had been instituted?

THE COURT: Put on Hill-Burton.

WITNESS: There comes a time when Vanderbilt's Hill-Burton commitment is satisified for that year, too, Your Honor.

THE COURT: We've been talking about that for four or five years. Go ahead.

WITNESS: So some of the patients I had were also caught in that situation, that when Vanderbilt has a stated amount per year they have to honor in terms of Hill-Burton, that can be exhausted in a few months. So that for some of the patients over this five month period I was talking about, that was part of the problem was that that recourse was not available.

Q. (Miss Garner) What action if any would Vanderbilt take for a patient who was not covered by Hill-Burton, or who had exhausted Hill-Burton availability, and also exhausted Medicaid coverage, once that person had been admitted and Medicaid coverage expired, what would Vanderbilt Hospital do?

A. If they were an emergency admission, they would admit them and then they would be billed.

THE COURT: Her question was, once you get them in there, you're stuck with them, all you can do is bill them; is that right?

WITNESS: Right.

THE COURT: You keep them?

WITNESS: Keep them.

Q. (Miss Garner) Miss Moores, did you experience any kind of pressure as a social worker to move patients to other hospitals or to nursing homes?

A. There was that pressure in the sense there is utilization review at the hospital, and whether the patients have coverage or not, there is some need to confine their stay to what is usual in light of what they are being treated for.

Q. But in general as you responded to the Court's question, Vanderbilt Hospital would make a medical decision about whether to keep the eprson; would not purely on a financial basis move them out of the hospital.

A. That is true.

MISS GARNER: Thank you.

THE COURT: Are you talking about two types of dialysis? I'm not—I want to know what type were you talking about?

WITNESS: The peritoneal may be different now, Your Honor, but at the time I was there, only peritoneal dialysis, which is a method of treatment by putting fluid in the abdomen and draining back in and out over a number of hours as opposed to what we think of usually when we think of kidney machine where blood access is treated.

THE COURT: That's clear. I just wanted to be educated.

Cross-Examination

By Mr. Scanlon:

Q. Miss Moores, I believe you testified that you did a study of your own during a brief period of time you were at Vanderbilt with respect to five patients that you've indicated had a problem of getting into the hospital, and I believe they were all kidney patients, is that correct?

A. That is correct.

Q. The problem, the reason they were having a problem getting into the hospital, they didn't have any money?

A. That's right.

Q. Now, if you would, I believe we did this the other day when we talked, let's run through those five individuals, and I believe you said one of them was a problem twice, if I recall. Could you go through those five individuals and tell us what happened to them?

A. All right. Two of those were Medicaid recipients whose days were exhausted. At that time there were some—still some Hill-Burton funds available. And we were able to—I was able to arrange a commitment of Hill-Burton funds before they were admitted, and was able to get those two patients into the hospital.

The third patient was a young man who was very close to emergency status. We could not arrange his hospitalization any other way, and so we were able to make referral through Vocational Rehabilitation which as you know is not designed to respond in an emergency. Took some four to five weeks to—for them to go through the usual process, and the doctors managed to maintain this patient just short of emergency status while Vocational Rehab did their investigation and picked up his case.

Q. When you say picked up his case, picked up his hospitalization?

A. Right. And they have to agree to that before the person comes into the hospital. It's not anything that can ever be arranged once the person is admitted.

Q. So that is three of the five. Would you describe the other two?

A. And the other two were those people who had no coverage of any kind who were in hospitals outside of Davidson County, where the needed treatment was not available, and whose doctors were in contact with our doctors trying to arrange for them to be admitted to Vanderbilt. We were not able to do that, and

both of these patients were those who had to be allowed to deteriorate until they met the criterion for an emergency admission.

Q. With respect to these two individuals, do you know if they were Medicaid recipients?

A. They were not at that time. Now, one of those was the woman that I—they became Medicaid recipients on the basis once they were admitted to the hospital, or once they accumulated a large enough medical expenses they qualified under the spindown provisions of Medicaid.

Q. So one of the individuals—with respect to this individual, as soon as she became eligible, Medicaid picked her up; is that correct?

A. Yes.

Q. But prior to the time that she had spindown resources under the medical unit program, she was not eligible for Medicaid?

A. That is correct.

Q. With respect to the other patient I believe that accounts for four individuals, with respect to the fifth individual, was this individual eligible for Medicaid?

A. Became eligible when she had incurred enough medical expenses.

Q. So she was the same as the other individual, is that correct?

A. Yes.

Q. So at that time these two individuals were unable to get into Vanderbilt Hospital, and they were not eligible for Medicaid at that time; is that correct?

A. That's right.

Q. Now, Mrs. Moore, you've given some description here today about the difficulty for a patient in getting into a facility, into a hospital without funds. Is there also a problem, based upon your experience in working at Vanderbilt, for individuals who are in the facility, Medicaid runs out, insurance runs out, or Hill-Burton runs out, is this a problem with patients?

A. How we are going to pay things is a problem for patients as well as it is for anyone else, yes.

Q. It's a problem for the hospital, too, isn't it?

A. Yes.

Q. The hospital administration I take it doesn't particularly like to have patients in the hospital who aren't paying.

A. Not if they can help it.

Q. What effect does this have upon the individual when the number of covered days, or their money, whatever, runs out, what effect does this have on them from a psychological point of view, based upon your experience?

A. Some people worry very much about their hospital bills and the amount of bill they're running up.

Q. Isn't it true as you told me the other day, that you've seen it reduce patients to jelly, isn't that what you told me?

A. Some people are very anxious, very responsive to that, yes.

Q. Is there an inclination on the part of people at times to want to leave the facility when the number of days runs out?

A. I have occasionally encountered that. I would not say that is across the board.

MR. SCANLON: Thank you, Miss Moores.

Redirect Examination

By Miss Garner:

Q. I have one further question for you. Can you describe the effect you have observed upon patients and their families when these people are trying to get admitted to the hospital but are not able to be admitted?

A. That is much worse than worrying about the hospital bills after they get in. You know, if you have a choice of worries, worrying about whether you're going to live long enough to get the treatment, I would think, would outweigh how you're going to pay the bill after you get it.

MISS GARNER: Thank you, Miss Moores.

(There being no further questions, the witness was excused.)

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EVIDENTIARY HEARING, FEBRUARY 17, 1981

TESTIMONY OF JOHN GRANTIER

[Transcript of Proceedings, pp. 27-31]

Direct Examination

By Mr. Barrett:

Q. Mr. Grantier, you hold an A.B. degree in mathematics from Hamilton College achieved in 1958 and were employed from 1958 to 1967 with Mutual of Metropolitan, and from 1967 to 1974 with Minnesota Mutual Insurance Company, and from 1974 to date with Book and Company of Winston-Salem, North Carolina, most recently holding the position of vice president and senior actuary. You have been a fellow in the Society of Actuaries since 1971, and are a member of the American Academy of Actuaries and have been since 1970. Is all that correct?

A. Yes, sir.

Q. In the course of your employment with Minnesota Mutual

and more recently with Book, you had extensive experience with group insurance analysis.

A. Yes, sir, I have.

Q. In your employment for the last two and a half years, especially with Book, have you had extensive experience int eh analysis of health insurance products and projections?

A. Yes, I have.

Q. Would you read your testimony—

THE COURT: It's agreed to as read, and a copy will be furnished to the court reporter and she will incorporate it in the record at this point. Go ahead. I've read it, by the way, but I want it explained.

(Following is the "Summary of Expert Testimony of John Grantier."

"The cost of providing inpatient hospital services of Medicaid recipients with a limit on the number of days to be reimbursed per admission may be projected by an actuary in the same manner as one would project the cost of coverage of any health service for any group. The cost of inpatient hospital services with a per stay reimbursement limit would be the multiple of the rate of use of those services by recipients ("incidence rate") and the average cost of one inpatient stay ("average benefit").

The accuracy of the projection of the cost of providing inpatient services on the basis of a per stay limit would depend upon the accuracy and specificity of the data used by the actuary in formulating assumptions concerning the incidence rate and average benefit. The incidence rate (of recipient utilization of inpatient services) could be projected from the experiences of those states who provide inpatient services on a per stay limit basis. While this kind of data might need to be adjusted for such differences as climate and education and income levels for

recipients, data from neighboring states such as Virginia and Kentucky would provide a sound basis for an incidence rate projection. If comprehensive data on the rate of inpatient admissions were available for Tennessee recipients for a period of less than an entire year, a factor could be devised for allowance of seasonal variations in utilization.

Two factors would be essential to projecting the average benefit (or average cost per stay). The first of these is the average length of stay. Studies such as the Commission on Professional and Hospital Activities length of stay compilations for each region of the United States provide reliable data on which to base a projection. The second factor in projecting the average benefit is the average cost to the Medicaid program of a recipient day of inpatient services. A reliable projection would also take into account cost trend factors for hospital per kiem rates and hospital-based physicians' services. The projections of hospital costs and cost trends to be used in projecting the average benefit for a days-per-admission limit would be identical to those used in projecting the cost savings of a reduction in the number of days covered on a fiscal year basis.

I am confident that a reliable projection of the program cost of limiting reimbursement for inpatient services on a per admission rather than fiscal year basis could be projected from the data I have mentioned and other information generally available to actuaries could be made by a skilled actuary in approximately three working days.

By holding the utilization or incidence rate and per diem cost factirs as constants, and using the number of days to which Medicaid coverage would be limited for inpatient services (which will affect the average benefit) as a variable, projections would yield the number of days to which coverage could be limited to achieve costs within any projected budget.

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EVIDENTIARY HEARING, FEBRUARY 17, 1981

TESTIMONY OF JAMES E. WORD

[Transcript of Proceedings, pp. 50-54, 59-62 and 66-69]

Direct Examination By Mr. Scanlon

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MR. SCANLON: I appreciate that, Your Honor. I would like, however, to call the witness's attention as a preliminary matter to one of the exhibits that has been filed by the defendants, and, Mr. Word, I call your attention to Defendant's Exhibit 2. (A-167)

THE COURT: You haven't filed that yet.

MR. SCANLON: Yes, Your Honor, I gave you a copy. Perhaps your clerk has it.

(Document passed to the Court.)

MR. SCANLON: If Your Honor would like to follow on yours, it's on page D-2 of that exhibit. [A-167]

Q. (Mr. Scanlon) Mr. Word, this document indicates the Medicaid expenditures, fiscal years 1975 through 1981, and with each year, fiscal year '75, fiscal year '76 and so on, there are three separate columns for each of the fiscal years. I believe you have that chart before you, sir.

With respect to the column—let's take fiscal year 1975 as an example, column indicates the number of users, then the next one indicates the number of eligibles. Could you tell us what those two categories are?

A. Number of eligibles are those people who are eligible for the program. You can see that it has remained virtually constant.

Q. Just identify the categories of eligibles, in other words, of number of people that have Medicaid cards issued to them.

A. That is correct. That is the number of people we mail Medicaid cards to.

Q. The column of users—

A. The people utilized Medicaid services, roughly forty-five percent.

Q. Pull their card out of their pocket when they go to the hospital to use it, is that correct, or for whatever medical services—

A. They are those who did use it in fiscal year 1975.

Q. The difference between what would be eligible and users accounted for, as I understand it, Mr. Word, and correct me if I'm wrong, many people automatically issued Medicaid cards, whether or not they need medical services, may never ever use the card; is that correct;

A. That is correct, there are certain categories that are eligible.

Q. The third column again for the year 1975, there is a figure. Is that a total dollar figure?

A. That's the total dollar figure, comprised of state and federal.

Q. And would you explain, this is total amount of money spent on the program, you say state and federal, could you for the record clarify that?

A. If you look at the first year, 1975, you'll see a hundred and thirty-six point seven million dollars spent, of that 37.7 million was state dollars, 98.9 was federal dollars. That reflects seventy percent federal participation and thirty percent state participation that we talked about before. That's reflected in each of the subsequent fiscal years.

Q. And for fiscal year 1981 on through, what is the fiscal year this represents, what does it run from, from what to what?

A. Runs from July 1st to June 30th, state fiscal year.

Q. So fiscal year 1981 would be the current fiscal year, is that correct?

A. That is correct.

Q. If you could, Mr. Word, looking at the number of users on the Medicaid program over the years, would it be fair to say in your opinion the number of users remain somewhat constant?

A. It has fluctuated somewhat, but it has remained virtually—virtually constant, no dramatic changes.

Q. Would that be a fair characterization of the number of eligibles on the Medicaid program?

A. That is a fair characterization of the number of eligibles, right.

Q. With respect to cost, Mr. Word, how does that chart look with respect to costs?

A. It's obvious, beginning back in 1979, and as this chart reflects from '75 forward, the cost has dramatically gone up from in '75 136.7 million to projection in fiscal year '80-81 to 430 million.

Q. Basically, Mr. Word, in the last, oh, six fiscal years, seven fiscal years, what is reflected on the chart, the Tennessee Medicaid program has in fact served the same number of individuals, but the cost has been dramatically increased?

A. My one sentence analysis of that chart is that recipients are using more units of service at a higher cost.

THE COURT: It's interesting from 1979, '80, '81, it went up about forty—from that time went up about 40 million a year, roughly.

WITNESS: Yes, it seems to run about twenty percent.

* * *

Q. Mr. Word, we were in Court here in August in preliminary injunction hearing at which time the State of Tennessee was attempting to implement numerous changes in the Tennessee Medicaid program, and could you indicate for us the reason why back in August, to bring everybody up to date, why those changes were proposed?

A. We proposed changes in the Medicaid program in this fiscal year because there was a 388 million dollar appropriation for program services for nursing home care.

We analyzed early in the fiscal year that the program at its current expenditure level and current scope of services would expend 430 million dollars. And as you can see, there is a 42 million dollar difference.

We proposed, went through rule-making, attempted to make changes in the Medicaid program to reduce it by 42 million dollars or to reduce the growth by 42 million dollars and stay within the appropriation.

Q. Now, Mr. Word, at the present time, it's the month of February, as I understand it, none of these changes have been implemented; is that correct?

A. That is correct.

Q. Does the Tennessee Department of Public Health still desire to implement all of these changes that it proposed back in August?

A. With the exception of three that we have withdrawn, we would like to implement the rest.

* * *

Q. (Mr. Scanlon) Mr. Word, let's move specifically now to the area of in-patient hospital change in the program.

THE COURT: That's 20 to 12 days.

MR. SCANLON: Twenty to 14, Your Honor.

THE COURT: Okay.

Q. (Mr. Scanlon) Mr. Word, what is the Medicaid program presently spending a year—let's pick whatever fiscal year you have figured for, indicate the cost of the in-patient hospital—

THE COURT: Let me—can I interpose a question, not an objection?

MR. SCANLON: Yes, sir.

THE COURT: Can you tell me why 20 days was picked originally? I may have known and forgotten if I did.

MR. SCANLON: Your Honor, to be quite candid, I participated in that discussion, and as far as I know, had no scientific basis.

THE COURT: No magic to it?

MR. SCANLON: No.

THE COURT: Did the federal government have 20 days as a suggestion?

WITNESS: They approved the 20 days in our state plan.

THE COURT: No, that's not quite the same.

WITNESS: I'm sorry, I didn't understand.

THE COURT: Did they have a requirement for 20 days?

WITNESS: No, they did not require it.

THE COURT: What is the normal—is there an average, is there—when you look at the various states who participate, do they have an average of 20 days, do a lot of them have 20 days, or do you know?

WITNESS: Yes, sir, in looking at the other states, I'll give you my opinion of that, my opinion of that is in looking at other states by and large the 20 days in-patient hospitalization would be conservative compared to other states.

THE COURT: What does that mean?

WITNESS: That means most states have either different method of doing it or they have more days. Some are unlimited like for example, Maryland has unlimited. There are some states who control the—particularly control length of stay by diagnosis. There are some states, one state proposed to give recipients ten in-patient hospital days every six months. So there are a variety of ways of doing it.

THE COURT: No uniformity in practice or prescribed by the Federal Government?

WITNESS: No, sir.

THE COURT: In the grant program.

WITNESS: No. The only uniformity in my opinion prescribed is uniformity relative to method of reimbursement, not how many days the recipients have.

* * *

Q. (Mr. Scanlon) Mr. Word, could you please indicate to us why the State of Tennessee desired to reduce the number of days from 20 to 14, was there any reason other than trying to save some money?

A. There was no reason other than fiscal constraints, needed to save money.

Q. Was there anything magical about 14, 13 or 15? It was simply 14 is where the money was, is that correct?

THE COURT: Had to save so much money, so many days, so much money, is that correct?

WITNESS: That's how the fourteen was chosen. In fact, after the fourteen was chosen, before it was ultimately decided on, we looked at certain information relative to who we served fourteen days. And you are right, how that number was chosen was backed into.

Q. (Mr. Scanlon) Could you project the savings to the Medicaid program if the program were allowed to reduce the cap on its in-patient days from 20 to 14, what the savings to the program would be for the fiscal year 1981-82?

A. Realizing this is a projection, Judge, we had estimated approximately 13 million dollars by the reduction from 20 days, currently down to the 14 days maximum level.

Q. This is roughly a ten percent saving, is that correct?

A. Yes.

Q. Now, in addition to reducing the number of in-patient hospital days from 20 to 14, does the Department wish to deal with the cost of hospitals in any other way, just look to reducing the number of days or try to save some costs elsewhere?

A. There were three other items that we proposed. One was application of third party benefits so that the state would get credit for the third party benefits the recipients might have and save about a million and a half dollars.

THE COURT: You're talking about Hill-Burton, private insurance?

WITNESS: Talking about predominantly, Your Honor, about private insurance.

THE COURT: Save about how much?

WITNESS: 1.5 million.

Q. (Mr. Scanlon) Mr. Word, just to make it clear for the Judge, the program now does apply private insurance, and the change would be the methodology which it is administered, and this is where the savings would come.

A. That is correct. What is essentially would do is say that regardless of whether you have third party insurance or what, everybody got twenty days. As it is at the moment, Medicaid recipients with insurance, get the twenty days plus however much insurance pays for.

We have, Your Honor, a directive from the Federal Government that we are out of compliance because we have not—we have not instituted this applicable—what I'm calling application of third party. They are saying everybody should get twenty days, even if they have third party insurance or whatever. We

haven't implemented that, but we have been directed by the Federal Government that we are out of compliance.

Q. Now, you said three other things. What are the other two that you wanted to do in addition to reduction?

A. Second was limitation on Friday, Saturday admissions, so those admissions would occur only in emergencies and only when surgery was on the day following. That was roughly three—approximately $300,000.00 to be saved in that one.

I mention that, the third one is that we were going to amend our method of reimbursing hospitals, piace a penalty on hospitals with vacancies, vacancies below ninety percent. That when we were told that we had to have prior approval on that one, that's a thirteen—that would have saved 13 million dollars, that's the one that we dropped and traded off to do the reduction in days.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his next friend, Kathleen Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor, State of Tennessee, et al.,
Defendants.

EVIDENTIARY HEARING, FEBRUARY 17, 1981

TESTIMONY OF WILLIAM B. SHAW

[Transcript of Proceedings, pp. 76-109]

Direct Examination

By Mr. Scanlon:

Q. Mr. Shaw, for the record, please tell us where you live and where you are employed and in what capacity.

A. I live in Nashville, Tennessee. I'm Program Director for EDS Federal in Nashville. We are the fiscal agent, contractor to the State of Tennessee.

THE COURT: What are you program director of?

WITNESS: Program Director of EDS Federal, that's Electronic Data Systems Federal, which is a private corporation. We are a contractor to the State of Tennessee. We process the claims for the Medicaid program, using benefit outlines given to us by the state.

Q. (Mr. Scanlon) Mr. Shaw, you did not formulate any policy for Tennessee Medicaid program; is that correct?

A. We do not.

Q. Basically the system that you utilized to process claims is a computerized system; is that correct?

A. Yes, it is a computerized system.

Q. Mr. Shaw, throughout the course of the last several months, have you been requested by the Department of Public Health to call upon the data you have available to you through the claim processing system to put together some charts and summaries with respect to some of the changes proposed changes in the Medicaid program?

A. That is correct.

Q. Mr. Shaw, if you would, please, I call your attention to Defendant's Exhibit No. 4-A—[A-170]

(Passed to witness.)

That would be headed at the top, I believe, "Table 1," [A-170] is that correct, Mr. Shaw?

A. Yes.

Q. Now, with respect to Table No. 1 [A-170], was this prepared by your firm?

A. Yes, Table 1 was prepared by us.

Q. Was it prepared either by you or under your direction?

A. It was prepared under my direction.

Q. Could you tell us the source of the data and the years that it covers?

A. The data in Table 1 [A-170] is taken from paid claims from the service year of fiscal year '79 and '80, so it's beginning July 1, 1979, and ending June 30, 1980, service dates.

Q. And you said by paid claims, could you explain maybe that a little bit for the Judge?

A. This data is based upon claims that have been paid by the Medicaid program.

Q. I believe the terminology used, you scan those claims, and on the computer brought forth this data.

A. Yes, we selected all those claims and accumulated the data for this report.

Q. Now, if you would, Mr. Shaw, if you would, take and go through the first column on Table No. 1 [A-170], number of days utilized, and indicate what that represents.

A. Number of days utilized is just—it's what it says, it's the number of days utilized by a recipient.

Q. So in other words, between the parameters zero through twenty; is that correct?

A. Yes.

Q. Then it's broken down going across the top, medically needy, categorically needy, those are the categories of recipients of Medicaid?

A. Those categories for all recipients.

Q. The total would be the next column?

A. That is correct.

Q. Example of the Medicaid people who are eligible, who actually used Medicaid for in-patient hospital services for two days, that total would be what, Mr. Shaw, if you could identify it?

A. 8,989 used Medicaid, recipients who used two days.

Q. This would go all down the line from up to the 20 day period, is that correct, up through the 20 days?

A. That is correct.

Q. Now, I call your attention to—

THE COURT: Now, I think I understand this, but I want to be sure. On those that stayed 15 days, you have 565, that 565 is not added into any of these other figures?

WITNESS: It's not added in, it's unduplicated.

THE COURT: Unduplicated. All right.

MR. SCANLON: Your Honor, under the total at 15 would be all the way over at 685, that would be—

THE COURT: Yes, I understand, just using the first figure.

Q. (Mr. Scanlon) Mr. Shaw, get down to the 20 days, it's what we commonly refer to as the ballooning effect, at the 20 day, could you explain the figures at day 20, why they are so much greater than the other days?

A. At day 20 you will note there are 4,273 users in the total column. Actually that balloon is created there because of the current cap at 20 days. Providers of service have billed for twenty days to the program. The remainder of the days of those stays are not shown to the program, so that's why we show a large number of users at 20 days.

THE COURT: Say that again. There is a cap of 20 days—

WITNESS: There is a cap of 20 days. For example, Your Honor, note 19 days you have 495 users.

THE COURT: But you are saying accumulate 20 days, those 20 days, 21, 25, 30 days.

WITNESS: That is correct.

THE COURT: All right.

Q. (Mr. Scanlon) Mr. Shaw, I believe there was some testimony earlier by Mr. Word, to clarify the record, does the

Tennessee Medicaid program or your corporation specifically keep track of the number of recipients who, even though we only pay—the program paid for 20 days, were actually in the hospital for 21, 25 or 30, in other words, if you were to graph it on out, these people at 20 days, would you be able to tell us how many people Medicaid recipients only 20 days were paid for, but were in the hospital 25 days?

A. No, we can't. There is a place to provide that information on the claim form that went in, began use December 1st, 1979, but it is not required that the hospital give us that information. Some do, some do not.

THE COURT: Well, now, I don't know if this is going to be particularly important. Would you tell me on line 14 when you say accumulated users effective, you're talking about—and you have 7279, is that the total or is that something—what does that mean?

WITNESS: Well, Your Honor, what that means is that that says if you were to limit the day coverage at 14, you would be affecting a total of 7,279, and that's arrived at by adding from your total column, the bottom there, you have 4273 people it would affect, you have 495, 534 and so forth, those numbers are accumulated by adding back up to get 7279. So these are the total number of people that would be affected by a change from 20.

THE COURT: Those numbers are accumulated.

WITNESS: They are accumulated, cumulative users effective,—we took the 4273 and we added in at 19 days you have 495 people, so we added those in to give 4768.

THE COURT: I'm with you.

Q. (Mr. Scanlon) Mr. Shaw, moving on over to the percentage of users served, if you could explain that column.

A. The percentage of users served was derived at by taking the cumulative users affected column, and you are applying the formula given below that, percent of users served equals total users minus the cumulative affected users over total users. One thing there I need to mention, if the bottom grand total users also included Medicare-Medicaid patients, patients who have coverage under Medicare-Medicaid program, we applied that formula to the cumulative users affected to give the percentage shown in the right-hand column.

Q. With respect to the Medicaid-Medicare user, it might be good to at this point to explain that a little. I had some testimony Mr. Word brought out, going to be summarized, what is Medicaid-Medicare users, I see backed into those figures some 47,051 recipients.

A. This is again unduplicated from the 51,000 number. These are people who have in-patient coverage under the Medicare program. They also have Medicaid coverage and Medicaid does cover deductible—deductible they incur under the Medicare program.

THE COURT: So you are actually talking about deductible, that's all as far as the Medicaid program.

WITNESS: We pay the deductible.

THE COURT: Deductible is what?

WITNESS: Currently $180.00.

Q. (Mr. Scanlon) Just to make sure the record is clear, is that for these Medicaid-Medicare individuas Medicaid will pay for numerous other services that aren't covered by Medicare, is that correct, Mr. Shaw?

A. Yes, since they have Medicaid coverage they are getting other services Medicare does not provide.

THE COURT: I understand.

Q. (Mr. Scanlon) So if you would, explain then the significance of the column that says, percentage of users served with relation to number of days column.

A. What this shows following this through then, shows for each line, if the program were to be limited at any of those points shown, 14, 15, 16, shows you what percentage of the people would be served.

Q. So in other words, Mr. Shaw, if the program were during the fiscal year 1979, had had a limitation of 14 days, then is it a fair statement to say from your data that 92.56 percent of all the Medicaid in-patient hospital users would have been covered?

A. That is correct.

Q. Mr. Shaw, I call your attention now to—unless Your Honor has any more questions on that chart—

I call your attention to Table No. D-4-C, [A-172] that's skipping one over with respect to minorities, unless Your Honor wants to—Table No. 2 [A-171], Your Honor, simply separates out the data with respect to minorities, but I believe it's been blocked from the lawsuit. I'd like to go to the handicapped table, No. 3, D-4-C, [A-171] Table No. 3, Mr. Shaw, if you could explain what this table is in relationship to Table No. 1. [A-170]

A. Table 3 [A-172] parallels in methodology what we just looked at in Table 1, only it has taken just that group of people identified as handicapped.

THE COURT: Wait a minute, now. Okay, go ahead.

A. (Witness) Got the percentage in the middle on this one. What we did, we took again and arranged the days from zero to twenty, combined zero to thirteen into one line for purpose of simplicity, and then identified unduplicated count of our disabled, blind users. Coming over to the center column with total handicapped users again unduplicated, which shows a total of

16,852. Bringing in the people who are served under Medicare-Medicaid program, 12,7547, we come to a total 29,609 total handicapped users.

And then the next thing on the very right-hand side of the Table 3, [A-172] cumulative users affected, again as you go to day 20, we have 844 plus 309 from day 19 plus 328 day 18 and so on. So give total—count of total users affected day 14, and apply the similar, at the bottom, similar to the formula used in Table 1 [A-170] to arrive at the percentage served of users.

Q. Mr. Shaw, if in fact during the fiscal year, 1979 and 1980, that the Tennessee Medicaid program had placed a fourteen-day limitation on in-patient hospital stay, based upon the data and chart, Table No. 3, [A-172] what percentage of the handicapped Medicaid recipients would have had all their in-patient hospital needs covered?

A. 84.4 percent.

MR. SCANLON: Your Honor, before I go on to another table, do you wish some questions?

THE COURT: No, no problem.

Q. (Mr. Scanlon) Turning over, Mr. Shaw, turning to Table No. 4, [A-173] which is on Defendant's Exhibit 4-D, D-4-D Mr. Shaw, if you will, go ahead and explain this table, somewhat different from the previous tables, and if you will, describe it, please.

A. Table 4 [A-176] takes the patient days in Table 1, [A-170] looked at the users, number of people served, and in Table 4 [A-173] we're looking at the patient days being served. So what we've done on the left-hand column, again, number of days utilized zero to twenty. We've converted that, some multiplication in there, to give you the total patient days by users who used one day and users who used two and so on. For example, we—all the users who used two day level had a grand total of

17,976 patient days. We apply that methodology to each of the day levels and then the grand total down to the bottom, to 348,512 patient days.

And then the next column, users affected, again applies the same methodology from the front page, pulls the users affected from there and lists them out. Then what has happened in the final right-hand column where it says patient days cut back, there is an analysis of the days that would be cut back based on the fourteen day limit. So we took—we have 4,373 users who used it at the 20 day level. If they now use at the 14 day level, that's six times—they lost six days, six times 4273 gives you 25,638 patient days. Or users at 19 days, 495, they lose 5 days, so 5 times 495, 4 times 534, and so forth. So the right-hand column is saying the total cut-back days now would be 34,123.

THE COURT: Less than ten percent.

WITNESS: A little less than ten percent, that is correct, applying the formula at the bottom comes to 9.79 percent.

Q. Mr. Shaw, with respect to this table, the previous tables had Medicaid-Medicare recipient figures involved, these would not show up on this table, would they?

A. That is correct. That is not here, users by Medicare-Medicaid people is not here.

Q. That is by virtue of the fact outside the payment of deductible you did not process claims for Medicare.

A. That is correct.

Q. Mr. Shaw, just one final table. I call your attention to Table No. 6, Defendant's Exhibit D-4-F [A-175]. Again, if you would, go ahead and walk through this table and explain to the Court it's significance.

A. Table 6 [A-175] is patient days impact analysis paralleling what we did for Table 4, [A-173] except just working with the

subgroup who are identified as handicapped. So we have accumulated in the second column from the left, we have accumulated total patient days for total of 162,703, and brought out users affected from Table 3, [A-172] and then multiplied by the number of days cut back. So 2044 times 6309 times 5 and so forth to go on to the right-hand side of 6 shows total days cut back for the handicapped individuals and that totals 22,154 patient days. Comparing that 22,000 to 160,000 shows about 13.61 percent of the handicapped patient days being cut back.

Q. Again, Mr. Shaw, that's 13 percent total of all patient days for the handicapped.

A. That is correct.

THE COURT: The impact on the handicapped is 3.82 percent more than the total.

WITNESS: Yes, that is correct. This compares handicapped cut-back to total handicapped utilizers compared to all cut-back to total utilization.

THE COURT: Yes, I understand that. The 3.82 percent is the impact on handicapped as compared to total loss of days for the entire program. Is that not right?

WITNESS: I didn't do the subtraction myself.

THE COURT: 9.79 from 13.61, I think that's 3.8.

MR. SCANLON: Your Honor, I believe there are some other backup tables and charts in the study done by Mr. Shaw. Unless the Court has any questions on those, I have nothing further of this witness.

THE COURT: All right.

Cross-Examination

By Miss Clasbey:

Q. Mr. Shaw, I have some questions about defense Exhibit 4-A, Table 1 [A-170]. That is an analysis of all users. Does that include handicapped users?

A. That does include handicapped users.

Q. What would you need to do to analyze usage for non-handicapped users as opposed to total users, where would you make changes?

A. Well, your non-handicapped users would be what is left after what you had in Table 3. [A-172]

Q. You would take Table 3 and subtract those numbers from the numbers in the same places on Table 1 [A-170]?

A. What you applied in Table 3 [A-172], your population is either handicapped or non-handicapped, and what you had in Table 3 [A-172] is a compliment of the non-handicapped.

Q. So in order to determine the impact, say if you wanted to determine percent of users served when you're talking about non-handicapped population—

THE COURT: Subtract 29,609 from 98,121 and apply the formula.

Q. (Miss Clasbey) Is that correct, Mr. Shaw?

A. Depends on whether you're going to keep the Medicare-Medicaid, that is correct, you've got Medicare-Medicaid in both of those.

THE COURT: Both of those?

WITNESS: That's right.

Q. (Miss Clasbey) If you wanted to make these calculations—

THE COURT: Let's do that right now. Let you do that. Pull the handicapped out and use your pencil and tell me what the percentage is.

(Pause)

Q. (Miss Clasbey) I'll ask you to also subtract Medicare.

THE COURT: You don't mind if I do mine first?

(Pause)

THE COURT: Leaves 68,512, is that right?

WITNESS: Right.

THE COURT: Going to divide now, you give me percentage now. Where are you going to get your divider?

MR. SCANLON: If Your Honor please, I have a calculator Mr. Shaw might use if permissible.

THE COURT: I don't know if we have the data. Looks like we've lost one.

WITNESS: On Table 3 [A-172] you have your cumulative users affected, some 4617. Cumulative handicapped. That's really cumulative handicapped. That's really cumulative handicapped users affected. So the other ones are non-handicapped users affected. We've got Table 1 [A-170], you've got 7279. 7279, those are your total users affected.

THE COURT: Less 4,617.

WITNESS: Right.

THE COURT: 2662. As compared to—

WITNESS: 68,512. You have to take 68,512 minus 2662 over 68,512.

(Figuring)

Your answer would be about 3.9 percent cut-back, something like that.

Q. (Miss Clasbey) I didn't follow the calculation. What was it you came out with?

A. Okay. This calculation removed the handicapped people from the analysis, if I understand your question correctly?

Q. Right.

A. So step one, to remove them was you took from Table 1, [A-170] 98,121 people, which is your total population. You subtracted out from Table 3 [A-172] your total handicapped population, 29,609. That left you with 68,512 non-handicapped people. Then to get to the non-handicapped users affected by the cut-back, you took grand total from Table 1, [A-170] grand total users affected, 7279, minus your handicapped users affected, 4617, from Table 3, [A-172] to give you 2662 non-handicapped users affected. And then you convert that to a percentage, depending on whichever way you want to look at it, if you want to look at it as I have in these tables, percent of users served, it comes out to 96.1 percent of non-handicapped users served. If you look at the converse percent of users cut-back affected by the change, then it's about 3.9 percent.

Q. Which day are you talking about?

A. At day 14.

THE COURT: 3.9 percent, three point nine point something, the other way, impact analysis on handicapped users was three point eight, two.

Q. (Miss Clasbey) As I understand what you've testified to earlier, Medicare does not pay in-patient hospital days per se for Medicaid. Medicaid does not pay in-patient hospital days for Medicare recipients; is that correct?

A. No, Medicaid reimburses the in-patient deductible, $180.00 payment that the Medicare patient must incur upon admission.

Q. That's Medicare deductible?

A. That is correct.

Q. So then a cut-back in the number of in-patient days Medicaid pays for, does that have any impact on Medicare recipients?

A. No, these people Medicare-Medicaid patients will still receive full benefits, full coverage.

Q. How long does the Medicare patient get coverage in the hospital?

A. Medicare a little bit more complicated, it's by spell of illness. They receive sixty days and then some new rules come into play, between sixty and ninety, before ninety to a hundred and twenty, some other rules.

Q. So if you want to—wanted to analyze the impact these cuts are going to have on people who are going to be affected by these cuts, you would subtract Medicare out of that analysis, wouldn't you?

A. I don't know, because another way of looking at it is to remove them from that, but at the same time these people are still receiving their full coverage by the programs combined.

Q. But as to people who stand to lose on benefits by the cut-back from 20-14, Medicare people in that population?

A. That's why they're here, even with the program cut-back to 14 days, still not going to lose benefits, still keep their benefits.

THE COURT: Benefits, $180.00, that's not days. She says they are in there erroneously. And I see that she might have a point.

Q. (Miss Clasbey) In order to figure your calculations excluding the Medicare population, simply use the same formula but use the total before you add in the Medicare-Medicaid recipients.

A. You could apply the same formula below your total users on Table 1, [A-170] would be 51,070.

THE COURT: Figure that one out for us.

WITNESS: Okay.

THE COURT: On the 14 day.

WITNESS: Okay.

(Figuring.)

That shows 85 percent, so where you have 92.56 percent being served, this shows 85.7 percent being served when you pull those people out.

Q. (Miss Clasbey) Is it possible to make this analysis as in Table 1 [A-170] by excluding the Medicare population, Medicare-Medicaid, and for the non-handicapped only population?

A. Yes.

THE COURT: Go ahead and do it.

WITNESS: (Figuring.)

MR. SCANLON: Your Honor, I'm not sure what the witness was asked. I have trouble hearing.

MISS CLASBEY: I was asking if it were possible to do the same analysis for population of non-handicapped users after having subtracted out Medicare-Medicaid recipients.

WITNESS: Okay. Applying this same methodology that we did for non-handicapped with Medicare, and when you back—your non-Medicare, and when you back—your non-

Medicare back to analyze your non-handicapped, you have 2662 non-handicapped against, as we did previously, the same we did previously in analyzing just Medicaid only population, take 51,070 minus 16,852 who are your handicapped users, give you 34,218 non-handicapped users. Applying that calculationo the—come to percentage, and it gives 92.2 percent. So you're serving 92.2 percent of the needs of the non-handicapped users.

Q. (Miss Clasbey) At what—

A. At 14 days.

THE COURT: That's the same thing as with handicapped, that's 14 days.

WITNESS: Want me to repeat it?

THE COURT: I just told you. Figure the same thing at handicapped basis.

WITNESS: Okay.

Q. (Miss Clasbey) Handicapped, all you need to do is take handicapped out of Table 3. [A-172]

A. Right, take 16,852 from Table 3, those are your handicapped users.

THE COURT: All right, Table 6, [A-175] give me the percentage of cut-back days, cut-back with handicapped, you can't do it on days, can you?

WITNESS: No.

THE COURT: Give me what is the percentage of handicapped served on that basis? Will be served, you've already got that, 84 percent.

WITNESS: Right.

THE COURT: That's keeping Medicare in it. Take Medicare out.

WITNESS: Okay.

MISS CLASBEY: I'm sorry, Your Honor?

THE COURT: Table 3, [A-172] taking Medicare out.

(Figuring)

THE COURT: 76 percent?

WITNESS: That's right.

Q. (Miss Clasbey) Mr. Shaw, that's not the figure we've come up with.

WITNESS: I may have made a mistake up here on the spur of the moment, doing this.

Q. Would 72.6 be possible?

THE COURT: Well, let's see.

(Figuring)

WITNESS: I carried that to total users population to 51,070.

Q. Where do you get that number?

A. We said as we're comparing the percentage, want to get the percentage of non-handicapped users served, right?

Q. I believe we already did that one. I may have misunderstood what you were doing. I thought you were computing handicapped users served, Table 3. [A-172]

A. We took 16,852 minus 4617 and that gives 12,235 non-handicapped users served. What do you want to compare it to? I compared it to total population of users.

Q. (Miss Clasbey) My question was, using the formula that you have at the end of Table 3 [A-172] with the exclusion of the Medicare-Medicaid population, what would the result be?

A. Okay. So that is with total, in this case, total? 72.6. Now, that's 72.6 percent of handicapped users affected.

Q. At 14 days? So by excluding the Medicare population for handicapped users, 72.6 percent are served.

A. That's right. I just made an error. 72.6 percent being served, when you pull the Medicare people out.

Q. Right. For non-handicapped people, when you pull the Medicare out is—

THE COURT: 92.2.

WITNESS: Right.

Q. (Miss Clasbey) I just want to ask you a couple of short questions on Exhibit 5. You report in-patient stays by hospital and diagnosis, Exhibit D-5.

A. Exhibit D-5?

Q. Starts D-5.

THE COURT: D-5, A or B or what?

MISS CLASBEY: Attachment 1, Title, excessive in-patient days by stays by hospital. Is that per stay, would you explain that?

WITNESS: This chart—

THE COURT: What are you explaining in the first place?

WITNESS: As I understand, I'm explaining D-5-A which is entitled, "Attachment 1, Excessive In-Patient Stays by Hospital."

THE COURT: All right.

WITNESS: Okay. This report is based on six months of actual Tennessee Medicaid experience. The uses within the analysis, length of stay by diagnosis to look at each hospital in the state, and see how many days, how many patient days were provided by that facility in excess of 95 percentile length of stay criteria that's given in Column, Days in Excess of PAS.

THE COURT: What is PAS?

WITNESS: PAS, Professional Application Study, I believe the middle word is application, it's a compilation of nationwide and regional statistics. This is telling the amount of patient days that were covered, reimbursed by the programs in excess of the 95 percentile PAS.

THE COURT: That's per stay, PAS is an average of one stay in the hospital?

WITNESS: It's per stay, per condition, but what is here is summary, so—

THE COURT: Okay.

MISS CLASBEY: No further questions.

THE COURT: Step down.

(There being no further questions, the witness was excused.)

THE COURT: Call your next witness.

MR. SCANLON: Call Mr. W. K. Vaughn.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

EVIDENTIARY HEARING, FEBRUARY 17, 1981

TESTIMONY OF DR. W. K. VAUGHN

[Transcript of Proceedings, pp. 103-109]

Direct Examination

By Mr. Scanlon:

Q. Dr. Vaughn, if you would, please tell us where you are from and where you are employed, and your profession.

A. I am a bio-statistician, employed by Vanderbilt University School of Medicine in Nashville. I am an associate professor there with tenure, and I am the Director of the Division of Bio-Statistics in the medical school.

Q. Doctor, very briefly, if you would, tell us what does a bio-statistician do, what are the types of things you delve into?

A. Well, as an applied statistician, I delve into many different areas. Some examples, I teach medical students, teach graduate students the fundamental theories of statistics. I'm involved

with many investigators in the medical school in terms of analyzing their data using statistically sound principles. I am also principal investigator with several different contracts, one that's running right now has to do with determinants of outcome of kidney transplantation.

MR. BARRETT: Your Honor, we've offered to stipulate all the qualifications of Dr. Vaughn with Mr. Scanlon.

THE COURT: It's stipulated.

MR. SCANLON: Your Honor, what I was trying to do here was to elicit a little bit about the type of things Dr. Vaughn does.

Q. (Mr. Scanlon) Dr. Vaughn, over the last few weeks did I request that you perform an analysis of certain data with regard to the Tennessee Medicaid program.

A. Yes, you did.

Q. Doctor, I called you and did you in fact produce a report?

A. Yes, I did.

Q. What were you asked to do when you did the report?

A. I was asked to look at the data, data you presented, and to determine if there were disparate or disproportionate utilization in terms of handicapped versus non-handicapped Medicaid recipients.

Q. With respect to what aspect of the Medicaid program? You weren't asked to look at all—

A. No, just the data that you presented to me.

Q. With respect to in-patient hospital—

A. I'm sorry, with respect to in-patient hospital utilization, that is correct.

Q. Doctor, I call your attention to Defendant's Exhibit D-6 [A-179] in Collective Exhibit D-6 through D-C, D-6-B and C, [A-179-184] and does this constitute the analysis you did?

A. Yes, it does.

Q. Doctor, I wish at this time, if you would, to go through and tell us what you did, the data you arrived at, I think it might be best if you'd go ahead and explain it in terms—it's a little bit complicated, and I'll stop you at points along the line.

A. Well, the data you see which is labeled Table 1-D—6-C, [A-182] categorized in terms of non-handicapped and handicapped Medicaid recipients. The second column and the fifth column which are headed, Number of Recipients Receiving Service, are the number of recipients that have been previously alluded to by Mr. Shaw. When I was asked to analyze the data, I thought the best way to look at the data would be to look at it in terms of Medicaid eligibles, not in terms of number of recipients receiving service. My rationale for that was if you have more eligibles in one category than the other, you look at the total numbers of handicapped and non-handicapped who utilize the service in the category that had more eligibles, you would be expecting a higher usage rate. But that wouldn't necessarily reflect—would not necessarily give an accurate reflection of the actual utilization rates among the two eligible populations. So what I did was to compute something called person years of eligibility. The reason I did that was because in the category of non-handicapped and handicapped Medicaid eligibles, people are not entirely eligible during the year. Sometimes come on for a month and go off for a month. So I utilized the idea of person years of eligibility. What this means, you look at each month during the fiscal year, you compute the number of eligibles for non-handicapped and handicapped for that month, and you add all those twelve months up and you divide by twelve and that's the number of person years of eligibility for that period, and in this case, this analysis for 7/1/69 through 6/30/80.

Q. What you are telling us is that at any one given month there will be a certain number of eligible Medicaid recipients at any one period of time, but if you add it up, total number of eligibles in every month, it would be much more than that because some people are on the program and go off.

A. That's exactly right.

Q. I believe the figures that you looked at of all the separate individuals who at one time or another were eligible for Medicaid during the year was in excess of 400,000.

A. In both categories.

Q. In both categories? Whereas at any given month, any given time, normally only 300,000 people are eligible.

A. That is correct.

Q. So what you tried to do was compensate for this phenomenon in order to come up with the utilization rates between handicapped and non-handicapped.

A. Right. Makes them more comparable in terms of eligibility status. So utilization rates then are calculated by taking two columns headed number of recipients receiving service in both categories, non-handicapped and handicapped, and dividing the number of recipients receiving service by the number of person years and coming up with utilization rate, which is given in columns 3 and 6.

For example, if you look at the number of days of in-patient service, day number 1, you see 3,467 recipients receiving service, and their utilization rate 13.4 persons hospitalized per 1,000 person years of eligibility.

You can compare that to —you can see what happens to the 932 on day 1 for the handicapped and their utilization rate is 12.1.

Q. Doctor, with respect to the utilization rates throughout the spectrum of going from one up to twenty days, how would you characterize utilization by the handicapped versus non-handicapped?

A. Well, I think that's fairly obvious from the table, if you look at days 1, 2—sorry, days 2, 3,—well, in most of the cases handicapped utilize at a higher rate, and for the life of me I can't figure out there day 2, I guess handicapped utilized at a lower rate, and that appears to be the only day that occurred. So in general, handicapped utilized at a higher rate.

Q. And this utilization, higher utilization holds true with the exceptions you cited throughout the whole period, is that correct, going from one to twenty days?

A. Yes, that is true.

Q. Doctor, as bio-statistician in your professional expertise did this surprise you, this higher utilization by handicapped?

A. Well, not really, because you know handicapped are generally sicker, and they are probably older population, so the differential didn't surprise me all that much.

MR. SCANLON: Your Honor, I have no further questions. I think the study speaks for itself.

MISS CLASBEY: No cross-examination.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF
TENNESSEE, NASHVILLE DIVISION

Civil Action No. 80-2043-NA-CV

In the Matter of

Rosier Jennings by his next
friend, Kathleen Jennings,
et al,
Plaintiffs,

vs.

Lamar Alexander,
Defendant.

The deposition of DR. JAMES E. WORD

[Transcript of Deposition, pp. 6, 14-16]

Direct Examination By Mr. Bonnyman

A. ... Now, on the hospital reduction, relative to changes in methods of reimbursement which pertains to the penalty on vacant beds, we have been notified by Region Four that we would, in fact, have to have prior approval on that, because that is change in the method of reimbursing for in-patient hospitalization. And that is—that would require prior federal approval.

Q. They have not, when you referred to Region Four you are talking about the Atlanta office of the Health Care Financing Administration?

A. That's right.

Q. They have not disallowed that they have only told you you must get approval before you implement it; is that right?

A. They wrote us and told us we would have to have prior approval. And to this date they have not indicated, to my

knowledge, either acceptance or rejection of that.

* * *

Q. I think you covered this at the preliminary injunction hearing, but am I correct that the basic goal of the reduction in covered day was the cost savings? Let me explain that question a little bit more.

As I understand the department's position, in the area of, for example, certain drugs that are being deleted from the formulary, there is an interest in saving money, but there is also a judgment being made that those drugs are not medically efficacious or contraindicated for which Medicaid is now purchasing the drugs.

In contrast, I am just asking to clarify whether there is any purpose in reducing the in-patient hospital days, apart from that of cost savings.

A. To my knowledge there was not.

Q. Does the department have any written self-evaluations of its compliance with its assurance of non-discrimination against the handicapped; to your knowledge?

A. Do we have any written—

Q. Self-evaluations.

MR. SCANLON: In what area of accomplishment by the Tennessee Department of Public Health: affirmative action, local health?

MR. BONNYMAN: I am sorry, nondiscrimination in the administration of the Medicaid program against the handicapped under Section 504.

MR. SCANLON: And this would be something in addition to what you have been provided in the production of documents?

MR. BONNYMAN: Right.

A. I honestly don't know. I mean I know that we have had specific inquiries which we have dealt with that have come from Office of Civil Rights. I know that Carol Mitchell, who is dealing with that, has worked specifically as relates to nursing homes and being—insuring that in the survey process it is completed.

But I know of two meetings, three meetings in the last two years I have had with O.C.R. people about these issues. But as far as a self-evaluation, I am not familiar with any, if there is any.

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

DEPOSITION OF SAMUEL MARNEY, M.D.

[Transcript of Deposition, pp. 17-32]

Direct Examination

By Mr. Ray:

Q. Let's talk for just a moment about the reduction in the inpatient hospital services. The State has proposed to reduce impatient hospital services per year from twenty to fourteen. Are you aware of that?

A. Yes.

Q. What effect, if any, wuld the limitation of fourteen days per year maximum have on your practice, in treating many of these disorders? And could you name some of the disorders and give examples, if you have them?

A. The patients that I admit to the hospital are primarily those with obstructive lung diseases which includes asthma, chronic bronchitis, and emphysema. A number of these patients simply require longer hospitalization for intensive therapy than fourteen days.

In fact, some of them require longer than twenty days. And the effect of sending a patient out before the treatment is completed is simply that he or she will be back in the same condition or worse in a very short time.

It is my practice to treat a patient in the hospital with one of these conditions, until the problem is solved for the moment. And this may vary from three or four days for the patient who has an acute but limited problem, to a patient that I recently kept in Vanderbilt Hospital, who was not a Medicaid patient, for fifty days.

And it seems to me that it would be appropriate, medically, to be able to treat a patient until the condition warrants discharge.

Q. Are you familiar with the concept of stay of illness in the inpatient hospital area?

A. Yes.

Q. Is it your understanding that stay of illness would be where there is a durational limitation on what Medicaid will reimburse for, for a particular stay, but there would be no limit applied on the number of times that the person could be admitted to the hospital?

A. Yes.

Q. From a medical point of view, how would the change from an absolute durational limit to a stay of illness standard effect your practice, treating the conditions which you treat?

A. It would help considerably, because with the absolute limitation on the number of days that Medicaid patients can be hospitalized, we often wind up treating patients in a suboptimum fashion as out-patients. Some patients are simply going to have to be admitted several times a year as emergencies, whether we like to admit that legally or not.

And I suppose there are mechanisms available whereby we can declare a patient an emergency and accomplish this. But it seems to me that Medicaid should recognize the fact that whereas some patients with asthma and obstructive lung disease may go for years without being admitted, a small number of them are going to have to be admitted repeatedly, several times a year, for an aggregate of much more than twenty days.

And it would considerably simplify the technical practice of medicine if that were available.

Q. Have you had any experience regarding trying to get someone whom is not in an emergency or an emergency situation, but trying to get that person with one of these disorders into a hospital, after they have either expended their Medicaid days or do not have coverage otherwise?

A. Well, almost everybody has been in admitting over at Vanderbilt Hospital, and I assume this would be true of other hospitals, has had to go to local county judges to ask for authorization of funds to admit a patient who absolutely required treatment. And if the patient has run out of Medicaid days, then that sometimes has to be done.

Q. Have you experienced difficulty, yourself?

A. Yes.

Q. Could you describe some of the difficulties that you have experienced?

A. Well, if a patient simply cannot breathe and has to be admitted to the hospital, then we have to find a way to do it. And that has happened repeatedly.

Q. Have you had, yourself, difficulty in getting patients admitted to the hospital, after either their Medicaid days has—have expired, or did not have third party coverage otherwise?

A. Yes.

Q. Could you describe some of those?

A. I recently had a patient in the hospital who simply dragged along at home until he was declared eligible for Medicaid, and once we got him covered, he was able to go out of the hospital and be a candidate for vocational rehabilitation.

But he had wheezing, coughing, shortness of breath, every day, so he was unable to do any work, whether he wanted to or not. He simply was not able to. And once we treted him for about eight days in the hospital, his chest cleared. He felt dramatically better. And that was directly the result of Medicaid, once it was available.

Q. Let me just ask a question in that area, that may enable us to just sum up your testimony and your opinion in this area. Would you state whether you have an opinion regarding any difference that it might make in a person having available Medicaid days, if the State went to a stay of illness standard, as versus having exhausted their Medicaid days under an absolute durational limit?

Do you have an opinion regarding that patient's ability to get back in the hospital, if the State were on a stay of day instead?

A. If I understand your question correctly—

Q. I am sorry.

A. —it would be very difficult for us to get a patient back into the hospital, after the twenty-day limit has been expended at the moment. If we did have a different policy that allowed the patient to be admitted for each episode of illness, it would save considerable effort on the part of the patient and the physicians, and it would inevitably lead to a higher standard of care.

We also would admit patients before they become critically ill, and have to be declared emergencies. And this almost inevitably would decrease the number of days that they have to be kept in the hospital.

Q. Dr. Marney, I don't know how you made such a clear answer to such a convoluted question. Thank you very much. Let me ask you one final question, and then Mr. Scanlon would like to ask you some questions.

During your testimony regarding the inpatient hospital services, you use some terms like it would be more simple. It would be a lot more efficient if we had a stay of illness. I want to make sure that your testimony regarding your opinion of it being better to go to an episode standard for the Medicaid program is based upon medical necessity and not on just any sort of administrative convenience. Could you comment on that?

A. I hope I conveyed the fact that some patients simply are going to have to be in the hospital more than the specific number of days that are currently allowed. And it would make sinse to me to have to admit this and from the outset, and have a set up that would allow us to admit patients when it is medically indicated, rather than when they are having a life-threatening emergency.

MR. RAY: That is all I have.

Cross Examination

By Mr. Scanlon:

Q. Doctor, I would like to first of all inquire with regard to the testimony on the antihistamines. And perhaps clarify some of the terminology we are using here. When you indicate that these drugs will not be available to your patients, is what you are saying is that Medicaid would not pay for them; is that correct?

I mean, we are not stating that these drugs aren't available to be purchased somewhere.

A. No, they are available in drug stores.

Q. That's right. And so when we talk about the drug not being available, what you are saying is that they through my clinic,

there is a large number of Medicaid patients who would be deprived of this supply of medicine at least from Medicaid.

Q. Doctor, with respect to your testimony on the hospitalization of your patients, you have indicated that you would find a stay of illness therapy or concept much more preferable than an ultimate cap or ceiling. I would like to explore just a little bit here — and I am not sure whether Mr. Ray qualified the business of the stay of illness.

Are you saying then there should be no limitation or ceiling on the number of days that should be provided by the Medicaid Program for a particular patient?

A. Medically, that would be the best plan.

Q. Right. In a concept of a stay of illness, did you perceive what Mr. Ray was asking you, was within that stay of illness, there would be a particular limit?

A. There is a surveillance committee at Vanderbilt, which looks at the length of stay, and requires faculty to justify holding a patient longer than the standard of care outlines for any given condition.

But if there are complications — and sometimes there are — then we simply keep the patient until the illness so justifies letting the patient go.

Q. What I am saying is that there have been developed, statistical data and given formularies, and I use that very broad term, formulary, which indicated length of stay for normal illnesses commonly referred to as the P.A.S., as I have heard it referred to.

A. Yes.

Q. Now, what I am asking, would you still favor a stay of illness concept as outlined by Mr. Ray, if, in fact, that there was imposed by the Medicaid Program, a cap by stay of illness — let

me give you an example. If, in fact, the Medicaid program would say for a female between the age of twenty and thirty-four, that if she were to go into the hospital under an uncomplicated, nonsurgery, maternity delivery of a baby, that the Medicaid program would pay for three days? This is what I am talking about.

And my understanding of a stay of illness, it wouldn't be just whatever is medically necessary, but there would be certain limitations that would be imposed across the board to all patients. Now, would you still find that preferable to an outside limit?

A. Yes, I would.

Q. Why, Doctor?

Q. Because some patients simply have to be admitted more often than a total of twenty days a year will permit. Assuming that one hospital stay might be four days and another might be fourteen days. The patient may, in fact, need three, or even four hospitalizations during the year.

Q. All right. Even with the limitations, would it also be — I would assume that you would want the limitation that would be placed upon the first spell of illness, by diagnosis category, or whatever, would have to be reasonably related to the illness; is that correct?

A. Absolutely.

Q. You would not want it to be an arbitrary type of thing where we would say we are going to pay, okay, one day here and two days there?

A. Yes. I don't mean to imply that I don't think there should be standards of care. That is what we call it. There should be. And there are carefully worked out average lengths of stay for various types of illness, which you referred to. I am in favor of that.

But the average length of stay for asthma or severe bronchitis may be ten days. And the patient may need to be in the hospital more than twice. And there are also, needs to be some room for some exceptions because a few of those people are going to have to stay longer than ten or twenty or thirty days.

Q. Perhaps even forty or fifty days.?

A. And so my point is simply that I am not making the law, but from a medical standpoint, there does need to be provisions for the few patients who need much longer than the average stay.

Q. Doctor, you indicated that there was a comment you made, and I want to perhaps clarify for me, you have this problem when people are in the hospital and they are running out of their Medicaid days — is that a problem — and I believe some language you used about the problem of sending them out. Could you describe that problem for me; what is this?

A. If a patient is admitted to the hospital for severe asthma, which means wheezing, chest tightness, shortness of breath, that is caused largely by bronchitis, by which I mean secretions so thick that they obstruct the airways, then the patient is going to continue to be short of breath until the secretions have been fully cleared.

Now, in some cases that can be accomplished in one week. In other cases that takes three weeks or longer. And my point is simply if we send this particular patient out before the secretions have cleared, and take the patient off the bombastic treatment that we use in the hospital, which the patient cannot duplicate at home, then the condition is quickly going to revert to the same or worse than when he came in.

And that is my point. That we need to treat some patients of this sort until they really have cleared, or we are going to take one step forward and two backward.

Q. The point I was trying to clarify is that in some people in the Medicaid program, or involved in talk about it, is the nineteen-day syndrome, where someone is approaching in the hospital — they are approaching the outside limits of their Medicaid. And I am sure this is true with people who have certain hospitalization insurance. Is it the patient's choice to leave the facility at the end of their coverage, for fear they can't pay the bill, or does the hospital say you have to go home at this point?

What is it that causes the person to go out of the hospital at that time? Does the hospital, in a sense, throw them out the door when their hospitalization goes off, or does the patient decide to leave, because they can't pay the bill?

A. Fortunately, a hospital may not throw a patient out, unless the physician says it is all right. Some of the patients do elect to go, because of the overwhelming bill that may ensue. But it is the physician's choice, in the majority of cases.

Q. I see. So this does —

A. I beg your pardon. In the cases I know of.

Q. I understand that is all you can testify to.

A. I don't know about the majority of cases.

Q. But what you are stating, though, is that at any point in time that an individual approaches limits of their insurance coverage or their Medicaid coverage, that this does create a problem for you in treating that patient? And as well as a problem for a patient, of course?

A. That is true.

Q. So that would be the case whether or not the limitation was twenty days, thirty days, whenever that individual gets that limit, there is a particular problem?

A. That is true.

Q. All right. And if we had a system set up of on a per spell of illness basis, and we applied a particular standard of X number of days, let's say referring back to the maternity patient, we applied to her a standard of three days. That if the doctor felt she ought to stay a little bit longer than the three days, and all that her insurance or Medicaid would cover would be the three days, she would have this same particular problem; is that correct?

A. She would have the problem of length of stay.

Q. Right.

A. And she couldn't get pregnant often enough to use up her twenty days one year.

MR. RAY: Excuse me, Frank, let him finish.

A. But for the greater problem, as I see it, for the people I treat, is that they may need multiple admissions in one year. And that we really don't have room for under the maximum number of days per year as we would per hospital stay.

Q. But even with the individual who would have the multiple admissions that would have to come in, and we could take from what you are expressing to me, and some testimony we heard yesterday, that people who suffer with asthmatic conditions do tend to come in for quite lengthy periods of time?

A. Some do. Some never are hospitalized.

Q. That even with these individuals that would come in and stay four or five times a year, they would face a problem when they would hit that limit for that particular stay?

A. That is true.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

DEPOSITION OF GEORGE MONTOURIS, M.D.

[Transcript of Deposition, pp. 17-20]

Direct Examination

By Mr. Ray:

* * *

Q. Okay. I want to ask some questions about your treatment of patients who require inpatient hospitalization. Do any of your patients require inpatient services?

A. Yes, sir, they do.

Q. Do you have any patients who have disorders who — which would require multiple admissions to hospitals?

A. The seizure patients could require multiple hospitalizations. Any of my stroke patients could because of complications that occur following strokes. The M.S. patients often require multiple hospitalizations.

Individuals who come for diabetes, diabetic neuropathy, occasionally they would be the less apt to have to be in the hospital several times because of a neurological disorder. Degenerative diseases of neurology often require hospitalizations. Degenerative brain diseases that we see, could easily because of the complications involved.

Another one that is hopefully not several hospitalizations but a prolonged hospitalization at the onset is Gillian Barre Syndrome G-il-l-i-a-n B-a-r-r-e Syndrome, that I recently had a child who is actually applying for Medicaid assistance who was hospitalized at Vanderbilt for a total of thirty days.

Q. Some of these diseases which require the multiple admissions, let's just take your stoke victim, for example. Typically, or specifically, if you remember a specific patient, what would be the first year's history, as far as hospital admission of a stoke, typical stroke victim? I am talking about as far as duration of stay times.

A. That would depend on the age. And that would depend on some of the possible causes of the stroke. If you are dealing with a relatively young person, and they have had a stroke, you would have to count, I would say, a minimum of two—I am thinking in terms of the tests that would have to be ordered. How aggresive you would get in the treatment, investigation, and ultimately possible surgery for it. So I would say you would have to count from the neurologist's point of view, barring the neurosurgeon who would then immediately follow if surgery was indicated, probably ten to fourteen days, minimum.

Q. Is that the first?

A. That is the first time. If you are dealing with an elderly patient, or not even extremely old, but say in your mid ages of fifties to sixties who may or may not have other complications, it is conceiveable in the non-operatable cases, that they would, if they continue to have strokes, that you would require at least two or three hospitalizations.

I am trying to recall some of the cases. Since I have an E.E.G. lab that travels throughout the counties, in the six months in operation, I can think of at least two or three cases that have had multiple hospitalizations with either an incephlopathic state or stroke, that has required that they be rehospitalized.

Q. Generally, how many days duration for each episode?

A. Well, you have to consider that the patients come in an unstable condition because that is the only reason you would hospitalize someone is that their situation is precarious.

I would say at least ten to fourteen days each time, because you need to have the individual stabilized. The aim is obviously to give optimal medical care. And they need to be stabilized before disposition can be taken elsewhere.

Q. I have one final question. How much are we paying you for your testimony and all of the time we spent together?

A. Nothing.

Q. Why are you doing it?

A. Because I believe in giving good medical care to people, irrespective of their financial income.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

DEPOSITION OF RICHARD STEIN, M.D.

[Transcript of Deposition, pp. 15-22]

Direct Examination By Mr. Ray

Q. Okay. Now, you have indicated before in your testimony, that you treat leukemia patients. And I believe you said some cases of acute leukemia patients?

A. That's correct.

Q. Does an acute leukemia patient require hospitalization?

A. Yes. THere has been a lot of progress in the management of patients with acute leukemia. Approximately ten years ago, acute leukemia was invariably fatal, and 90 percent of the patients were dead within two or three months.

Let me state that maybe fifteen or twenty years ago that was the case. I guess not all of the progress is in the last ten years.

At least at this time, however, eighty percent of the patients with acute leukemia have initially a favorable response, which we call a remission. And of this group of patients, many of

them live one or two years. And some of those patients are cured.

To treat these patients effectively, and to achieve these good results, we need to put patients in the hospital to administer drugs and more importantly, to give supportive care with antibiotics and transfusions of platelets, and occasionally, transfusions of white blood cells that these people cannot produce because they have leukemia.

The average hospitalization for someone with acute leukemia is three to four weeks. Some patients take as long as six to seven weeks during that first hospitalization.

These patients then need to come back in the hospital for what I would like to call, I think for simple purposes, touch-up treatments to keep them doing well.

And often they require to do that, three or four times during their first year of—the first year following diagnosis.

Q. That three or four times of in-patient hospital services?

A. That is the way we manage our patients routinely at Vanderbilt.

Q. And approximately—and I know we are generalizing here, but approximately how long for each of these subsequent admissions would be required?

A. For the drugs we usually use those subsequent hospitalizations last four to five days.

Q. Okay. Are there any other ailments which you treat, which also would require multi-admission to in-patient hospital services?

A. The one most obviously comes to mind, with respect to that question is sickle cell anemia. Our patients with sickle cell anemia are prone to have painful crises that can be precipitated by viral infections, or they sometimes are without any apparent

cause. These patients need to be admitted at the time of these painful episodes. They only have to be in the hospital only three to five days, but these episodes may occur once a year to five or six times a year.

So in our patient population with sickle cell anemia, we have a number of patients who will have four or five admissions to the hospital a year.

Q. Okay. Are you aware that the Department of Public Health has proposed to reduce in-patient hospital days on an annual basis from twenty to fourteen?

A. I am aware of that recommendation.

Q. Let's concentrate on the fourteen-day maximum per year limit. Would you state your opinion, if you have one, regarding your ability to treat those two diagnoses listed above, within that fourteen-day standard?

A. Well, with respect to patients with acute leukemia, you simply cannot effectively treat someone with acute leukemia with a fourteen-day stay in the hospital.

If you knew in advance that you could keep someone in a hospital for only fourteen days with acute leukemia, you would have to give them inadequate therapy, which would simply cut their chances of having a good response from eighty percent to probably twenty percent.

If you didn't know in advance and simply planned on treating the patient with what seemed to be the best therapy and sent them home at fourteen days, you would simply, by being unable to support the patients after fourteen days, kill all of the patients. You really can't do it.

Acute leukemia requires a month in the hospital at initial hospitalization, and there is really no way to manage a patient effectively with any fixed time. Of course, let me state, because what I said was a bit inaccurate, people with acute leukemia

need to be in the hospital until they go in remission. That takes on the average of three to four weeks.

But we have occasional patients who take six to eight weeks. The point is that the patient needs to be in the hospital, getting supportive care, until the bone marrow recovers. However long that takes it. And it is impossible to give any fixed time limit on what would be required there.

Q. Wouldn't that be the same problem if the standard were ad it is now, twenty days?

A. I have to state that both a fourteen-day standard and a twenty-day standard present equal problems, if one is going to deal with a disease like acute leukemia. That neither one of those time limits provides an adequate time frame to administer adequate therapy to that disease.

Q. Do you have an opinion, and if you do, would you state your opinion, regarding—and I am speaking strictly from a medical necessity point of view—the impact on your ability to provide medically necessary care to these individuals, if there is a set time limit per year, as versus a set time limit per spell of illness, or stay or illness? Do you have such an opinion?

A. Well, the ability to render the care would simply depend on the decision to be made by the admission on whether the patients would be admitted to the hospital or not. And whether or not Vanderbilt would choose to pick up when there is no available funding for the patients.

In essence, if a patient cannot be kept in the hospital longer than fourteen days, the patient cannot be treated.

Q. Let me state a hypothetical for you, and then ask you your opinion, if you do have one. Let's hypothesize a system of limitations on in-patient hospital services which would have no limit as far as an annual durational basis.

On an annual durational basis. But it would have a limit on the number of days that Medicaid would reimburse for per episode, or per stay. Let's just hypothesize that would be between ten and fifteen days per stay. As between a system which would impose an absolute maximum limit on in-patient hospital services, and a system that would impose a limit on a stay per illness in the in-patient hospital area, and reference in your opinion, if you give one, those two diagnoses which we had talked about earlier. The sickle cell anemia and the acute leukemia development. Your opinion, regarding which one of those standards would enable you to provide medically necessary care in a more efficient way.

A. Well, a system that gave a number of days per admission, with no limit on the total, would be better for the patients with sickle cell anemia, because you could bring them in when they needed to be in. You could render appropriate care for each episode and there would be no limit.

The patient with acute leukemia presents a difficult problem under either system. Quite frankly, because that first admission that is—unless the limit is such that the first admission in first leukemia may be four to six weeks, and other admissions of another length. That first admission of acute leukemia presents a problem.

The point is, a physician—and all I can state is as a physician—is what people need and what kind of care people need. And when patients have acute leukemia, they need initial admissions that are long and usually need follow-up admissions that are of variable lengths. Let's say five to seven days, several times during a year.

And how one comes close to meeting that need is administrative. So, I can't really comment beyond that.

Q. But the sickle cell anemia, you would comment that it would put you in a better position to provide medically necessary care for these persons?

A. Yes.

Q. Okay. I want you to assume some more facts.

A. Okay.

Q. Assume that a hospital would not force you, as a doctor, to discharge your patient who had acute leukemia, after the number of days had expired for Medicaid coverage. Assume that.

A. (Witness nods in the affirmative.)

Q. And assume the same stay of illness standard. What would be your opinion, if any, then, regarding the treatment of those?

A. Under the assumption that the hospital would not compel discharge of the patient, which I would say, in view of my experience at Vanderbilt is, of course, a reasonable assumption, then the best system is one that allows multi-admissions with a length allowable for each admission, with no maximum on total.

Q. Just want to make sure that I understand your testimony. When you are saying best, what do you mean by best?

A. Oh, I guess—I am sorry—well, what I am saying is that I guess we were comparing two systems. I should say it is better to have a system that you could bring patients in on numerous occasions, then to have a system with fixed limits, where you may have difficulty getting a patient admitted into the hospital.

Q. Then I take it you are speaking, of course, within your expertise? You are talking about medically better?

A. I mean better, with respect to being able to treat the patient as the patient needs to be treated.

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his
next friend, Kathleen
Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor,
State of Tennessee, et al.,
Defendants.

DEPOSITION OF JOSEPH M. STINSON, M.D.

[Transcript of Deposition, pp. 17-22]

Direct Examination

By Mr. Ray:

* * *

Q. I want to ask you a few questions about the in-patient hospital service reduction, or proposed reduction. Are there any diseases in your specialty, which would require periodic episodical admission to hospitals over a period of a year?

A. Yes. I suppose the examples of asthma, which is episodic by definition.

Q. I know it is hard to state this, but if you had to generalize, regarding an asthma patient, how many times would that patient require in-patient hospital services per year?

A. How many?

Q. I am not talking about duration, at this point. I am just talking about times they would need to be admitted.

And if you have specific case histories from your practice, you, of course, could use them without naming the name.

A. Could I give a statement off the record?

Q. Yes.

(Whereupon, an off-the-record discussion was held.)

Q. (By Mr. Ray) The question was, has there been anything in your experience that would—

A. Well, part of the reason I said off the record is because my experience is getting to be pretty good. You know, the frequency of hospitalization is declining, because we see them in the out-patient setting, whenever they need to be seen.

Q. Okay.

A. If anybody starts getting short of breath. If they cough more, if their sputum turns color, we tell them to call us. We will see them if we are here, any day; appointment or no appointment.

And if it is in the middle of the night, we would rather for them to come to the emergency room, than to wait to the next morning to call us, regardless of the cost of the emergency room. It does not cost as much as a stay in the hospital.

Q. Well, even if it has improved, isn't it a fact, though?

A. I will say probably four or five times a year would be your typical asthma patient's need to be hospitalized.

Q. Is there any way to generalize about the duration?

A. With asthma, generally, control is not too difficult. I would say about ten to fourteen days.

Q. Each?

A. Each.

Q. Each stay of illness?

A. Some of them might be a little shorter and some of them might be a little longer. But we could usually get them improved pretty fast.

This is not the case, necessarily, with bronchitis. Chronic bronchitis.

Q. Is that another example?

A. This is another example. In some respects, it is similar to asthma, except it is more chronic. It is less episodic. It is more sort of continuous.

And these patients, when they have an exacerbation and come into the hospital, very often they have so little oxygen in their blood, it is almost incompatible with life. And they very often have to go through the intensive care unit. They have to have mechanical ventilation and intensive intravenous therapy and physical therapy, and the whole works.

Some of these patients can require thirty days before they really are able to leave the hospital.

Q. And it is likely that this stay would be thirty days each episode, or would it change?

A. There would be a range, probably from fifteen to thirty days.

Q. Per episode?

A. Right.

Q. And when we are saying that, we are talking about time required in-patient hospital to adequately treat these patients?

A. Yes.

Q. Are there any other types of ailments that will require these?

A. Broadly, any of the chronic diseases of the lung can require similar stays. Part of the reason is because regardless of the disease, the lungs tend to react the same way. So that one of the diseases we see quite commonly is called sarcoidosis. And when it becomes severe, the patient is very much like those with chronic bronchitis.

Q. What is that disease?

A. Sarcoidosis is a granulomatous disease. That doesn't mean anything special. It causes shadows on the chest x-ray. And if you cut some of them out and look at it, it looks very much like what you see in tuberculosis. But it is not infectious. We have no idea what causes it. It just happens.

Q. Does it effect the oxygen supply to the rest of the body?

A. Yes.

Q. How does it do that?

A. Well, you know, the lungs get oxygen for the whole body. So if the lungs can't get enough oxygen, then the whole body suffers. That is why most of these diseases are so serious.

Q. So, it effects the absorption of oxygen?

A. Right. We call it supply.

Q. Oxygen supply?

A. Right.

Q. Regarding these diseases that would require periodic in-patient services, can you give, from a medical point of view, your opinion regarding what would enable you to treat these diseases more effectively, whether a set standard or durational limit on in-patient hospital stays per year, or stay period on illness, per illness standard? Do you understand the question?

A. I think so. "X" number of days per year or "X" number of days per illness?

Q. Yes.

A. I think a stay per illness would be optimal.

Q. Why?

A. Well, we have talked about eposidic exacerbations requiring hospitalizations. And one illness, or one episode could use up all of a patient's days for that year, if it is on a day's per year basis.

And then the patient would have an acute exacerbation later on, he might not be able to get into the hospital and might die because of that.

MR. RAY: I believe that is all I have.

* * *

IN THE UNTIED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NORTHEASTERN DIVISION

Civil No. 80-2043

Rosier Jennings, by his next friend,
Kathleen Jennings, et al.,
Plaintiffs,

vs.

Lamar Alexander, Governor, State of
Tennessee, et al.,
Defendants.

DEPOSITION OF GORDON TURNER

[Transcript of Deposition, pp. 6-11 and 15-19]

Direct Examination

• • •

By Ms. Clasbey:

Q. Through your admissions and referrals, are you familiar with the admission practices of a number of hospitals in the area?

A. Yes, I am. I have practiced here 25 years.

Q. Okay. Are a number of your patients poor or receiving Medicaid?

A. Yes, they are.

Q. Okay. What is your experience when trying to admit a patient who has no remaining Medicaid coverage to the hospital?

A. Well, it is usually a fairly good hassle getting a patient in, if it is not an emergency or life threatening situation. It is really a hassle, unless it is a life threatening situation or an acute emergency.

If it might immediately become a life threatening situation, we could get the patient in. Then soon after admission we usually have problems keeping patients in. We have to try to get the patient stabilized or in such a condition as they can be referred or transferred to another facility that might accept a full non-paying patient or full self-paying patient.

Q. What is your experience with patients who in your judgment need hospitalization but are not in the emergency or critical situation in getting them in?

A. It is usually a pretty good hassle.

Q. What do you mean by that?

A. I mean that if it is somebody who needs care that is not life threatening, if I send them to the hospital, I will get a call back and they will say Dr. Turner, this patient's Medicaid days are out, or they have used up their Medicaid days and they no longer have anything. Would it be possible for you to treat her later or refer her to some place that will take care of indigent people?

That's the usual answer I get.

Q. Have you ever had occasion where patients could not get into the hospital because their Medicaid days were out, when you felt they should be in?

A. Well, recently—I will give an example.

I had a patient without a life threatening situation who needed to be in the hospital for surgery. She got to the hospital and she did not have Medicaid days left and, therefore, could you wait to do this procedure later?

If there is such a thing as a minor surgery procedure, this was a minor surgery problem, but if it were great, it might make her a little more profitable to do the things, but I had to delay this.

She is not being treated because of the fact of the Medicaid days running out.

Q. Is it possible for you to perform the procedure without her admission to the hospital?

A. No, not as an out-patient.

You mean to do the surgery on an out-patient basis?

Q. Right.

A. No, not in this case would that be possible, because of her lifestyle.

Q. So, at this point your patient has not yet received the treatment you recommended for her?

A. That's correct.

Q. Can you think of other examples in your experience of persons who have been unable to get into hospitals when you tried to get them in?

A. Yes, I can.

One was in an automobile accident and was later bleeding to death, and his story was he had been to all of the surrounding hospitals southeast of us, including Nashville.

He had been refused and finally wound up in our emergency room with no blood pressure and literally bleeding to death at the time we took him in. We just had no choice, and he was an indigent patient, and thank goodness he is now living.

Q. Do you have any idea how many hospitals he had been to before he came to Perry County?

A. His story was that he had been to four.

Q. Okay. Can you think of other examples?

A. There is one other example that I can remember; a lady who had an intermittent partial bowel obstruction, and she needed surgery, and this had to be delayed for several months until she got her Medicaid back. In other words, until her Medicaid year was out. Then we admitted her and did her surgery and she is doing okay.

Q. Okay. Any other examples you can think of?

A. Not right offhand, except I remember one with lukemia who was severly ill. His blood count was in the area of four to five hemoglobin, and he had acute lymphocytic leukemia, and I remember one of the residents at Vanderbilt was here that weekend working for me, and we tried to get this patient into hemotology in Nashville. Since he worked there, he thought he could do it, but he hit the same brick wall I did.

He didn't have any money. Therefore, we better wait until we can get something done. So, I carefully explained this to the hemotologist, that I would have to transfer him and get the necessary studies and blood smears.

Anyway, this man was an acute lymphocytic leukemia patient, and I tried to get him in to one of the medical centers in Nashville, and the resident who was working for me that weekend thought he could get him in Nashville without any problem. He had the same answer that I got; since he has no money and no way to reimburse, we just can't take him.

So, I explained to the hemotologist that if I get the tests that you need or want and preserve the blood and send it to you and if I get this patient on Medicaid, will you accept him and treat him then? Of course, the answer was yes.

So, I went ahead and put him in the hospital here, transfused him, and got the tests prior to the transfusions, and got him to be transferred and did get him on Medicaid, and he was admitted to Vanderbilt.

After he was admitted, several of the specialty consultants, the hemotologist, internist, oncologist, made the statement, "This local doctor screwed up the tests," because I gave him blood transfusions, and it kind of gave the family a hassle because he had been treated prior to admission and, therefore, they were at a disadvantage, technically, as to what drugs to give this type cancer, and I had done everything they had told me to do, because they made such statements about my care. All I was trying to do was try to take care of a patient.

He was refused because of lack of money.

Q. How would you characterize the ability of people without remaining Medicaid days to get into hospitals?

A. I would say it is a hassle.

If you go ahead and admit them, I get notes put on the patient's chart. I get calls from the business office, various and sundry from the hospital, stating now, you know this person doesn't have any more Medicaid days and we are losing money on this patient, so we need to try to make some arrangements. Maybe you can refer him to a facility where they take care of indigent people, and it is strictly, it seems to me, more a money matter than it is a treatment matter.

Q. Is it your experience that there are people who do not get into the hospital because they have no remaining coverage?

A. Yes, it is. They are delayed. At least they are delayed until Medicaid is reinstated.

Q. Is it due to Medicaid?

A. That's right.

Q. Do you have less difficulty getting admission for a person with some reamaining Medicaid?

A. No problem at all if they have a few days left....

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Cross Examination

* * *

By Mr. Scanlon:

Q. Doctor, I believe you mentioned four patients that you indicated you recall having difficulty getting into the hospital. I would like to ask some questions about those four.

First of all, you indicated that there was a woman, I believe, who needed some minor surgery and her number of Medicaid hospital days for that year had expired. Could you tell me what the condition was that you tried to admit her to the hospital for?

A. She had a chronic ulcer on the left knee, which had been preceded by chronic arthritic condition or chronic painful knee.

She had had orthopedic surgery done on the knee at times, too, and because of her poor standard of living—I am talking about filthy situations—it is just impossible to do anything to that girl and have her get well at home, because she cannot, under the circumstances keep her leg immobolized, which it would have to be for several days if this ulcer were to be repaired or excised and closed.

Q. Now, Doctor, that particular patient, she was on Medicaid at the time you tried to get her in the hospital, is that correct?

A. That's correct.

Q. All right. You recall when, approximately, it was that this situation occurred?

A. I would just roughly say four to six weeks ago.

Q. All right. Now, the second individual you indicated had trouble getting in the hospital was somebody trying to get some emergency treatment, is that correct?

A. Is this the man that was in the car wreck?

Q. Yes, sir.

A. That's right. He was out of the county. I believe Lewis County, perhaps Hickman County. I am not sure.

This happened four, five, six years ago.

Q. Was this four, five, six years ago, Doctor?

A. Yes.

Q. Was this individual a Medicaid recipient?

A. I don't know. I can't recall whether he was or not.

Q. Then there was a third individual you talked about, and correct me if I am not pronouncing this correctly, an intermittent partial bowel obstruction?

A. Yes.

Q. When did this situation occur?

A. That was about a year ago.

Q. Was this individual a Medicaid patient?

A. A Medicaid patient, that's correct.

Q. You couldn't get her into the hospital?

A. Well, I think I could have, if I had been insistent, but it would have been with a great deal of reluctance on the part of the hospital.

Frankly, I think it would have affected her care. As you know, a surgical patient has to have primary things concerning post operative care, and I felt that under the circumstances it would be better for her to be delayed, even though she was not completely obstructed bowel-wise. That is, her bowel was not completely obstructed. She can live, in other words, without surgery, but she would be much better off after the surgery, which she has been.

I felt if I had been insistent, that they probably would have treated her with a great deal of reluctance.

I tried to get her in Nashville at other hospitals, but they simply would not take her because she didn't have any money and was not a life threatening situation.

Q. Doctor, you mentioned a leukemia patient, and I was a little bit confused about that testimony.

You attempted, as I take it, initially, to take this patient into a hospital in Nashville, is that correct?

A. Yes, because I am not a hemotologist.

Q. At the time you initially attempted to get him into the hospital, was he a Medicaid patient?

A. No, he was not.

Q. All right. I believe you said you subsequently got him on Medicaid, is that correct?

A. That's true. He took the patient after that.

Q. All right. Doctor, outside of these instances that you recall, and I take it that there might be some that you don't recall—outside of these instances you are having trouble getting Medicaid people into the hospital, isn't it true that you normally don't have a problem getting Medicaid patients into the hospital?

A. If they have some days left. If they have a few days left, there is no problem, but I always get a note telling me how many days we have got to deal with the patient, and try to make arrangements to get them to some other facility or get them well enough to go home so that they won't be in the hospital for so-called uncovered days.

Q. Doctor, the point I was trying to make—and I understand and appreciate your testimony in that regard—but isn't it true

that most of the time the Medicaid patients that you put in the hospital do have days remaining?

A. I would say so, yes, sir.

MR. SCANLON: All right. Doctor, thank you very much. I don't have any further questions.

* * *

PLAINTIFFS' EXHIBIT P-4

April 14, 1980

Mr. William H. Thomas, Director
Office for Civil Rights
Department of Human Resources
Region IV
101 Marietta Tower
Atlanta, Georgia 30323

Dear Mr. Thomas:

Enclosed for your review are copies of the following information requested in your letter of April 1, 1980:

(1) Revised Methods of Administration for Title VI and Section 504

(2) Updated Non-discrimination Policy

(3) Revised Mailing List

(4) Revised Title VI Compliance Review Procedure

(5) Information to be Distributed to Employees, Vendors, etc. (in the process of being printed)

Ms. Carol P. Mitchell will serve as the Department's 504 Coordinator. A description of her duties appears in the Administration and Responsibility portion of the enclosures.

Our proposed date for implementation is July 1, 1980.

If there are questions about any of this information, please contact Ms. Mitchell at (615) 741-1614.

We look forward to hearing from you soon.

Sincerely yours,

EUGENE W. FOWINKLE, M.D.
Commissioner

EWF:SLM:ljc 2/10

POLICY STATEMENT

The Tennessee Department of Public Health reaffirms its policies to afford all individuals including the handicapped the opportunity to participate in Federal financial assisted programs.

Title VI, Section 601, of the Civil Rights Act of 1964 provides that:

> "No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Therefore, the Tennessee Department of Public Health will not, because of race, color, or national origin:

1. Deny an individual the opportunity to participate in or benefit from any service, financial aid, opportunity, or other benefit for which he is otherwise qualified;

2. Provide any individual with service, financial aid, or other benefit which is different, or is provided in a different manner from that which is provided to others under its programs;

3. Subject any individual to segregation or separate treatment in any matter related to his receipt of service, financial aid, or other benefit;

4. Restrict an individual in any way in the enjoyment of services, facilities, or any other advantage, privilege, or benefit provided to others under its programs;

5. Treat an individual differently from others in determining whether he satisfies any eligibility requirement or other condition which a person must meet in order

to receive aid, care, service, or any other health service;

6. Deny or offer any person an opportunity different from that offered others in any program or service; or

7. Deny a person the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.

Section 504 of the Rehabilitation Act of 1973 provides that:

> "No qualified handicapped person shall, on the basis of handicap be excluded from participation in, be denied benefits, or be subject to discrimination under any program or activity which receives or benefits from Federal financial assistance."

It is therefore, the policy of the Department of Public Health, that any discriminatory acts against the handicapped will be prohibited.

Discriminatory actions against the handicapped which should be prohibited are outlined below:

1. Deny a qualified handicapped person the opportunity to participate in or benefit from aid, benefit, or service;

2. Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

3. Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;

4. Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or

services that are as effective as those provided to others;

5. Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistant to an agency, organization, or person that discriminates on the basis of handicap in providing aid, benefit, or service to beneficiaries of the recipients program;

6. Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

7. Otherwise limit a qualified handicapped person in the enjoyment of rights, privileges, advantages, or opportunities enjoyed by others receiving aid, benefit, or service.

ADMINISTRATION and RESPONSIBILITY

A. Commissioner

The Commissioner of Public Health is fully accountable and has overall responsiblity for Title VI of the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973 for the Department.

In addition, the Commissioner has the primary responsibility for the Tennessee Department of Public Health's adhering to the rules and regulations governing non-discrimination on the basis of handicap as well as to the anti-discrimination rules set by Title VI relative to race, color or national origin.

B. Title VI/Section 504 Coordinator

The Title VI and Section 504 Coordinator is responsible and accountable to the Commissioner for coordinating a comprehensive and complex Title VI and Section 504 program for the Tennessee Department of Public Health as mandated by the United

States Department of Human Resources. The Coordinator is responsible for ensuring that any program or activity which receives Federal financial assistance adheres to the regulations governing Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 19733 are actively approached and difficulties in meeting the terms and conditions are eliminated.

The responsibility, limitations and authority vested in this position include the following:

1. Disseminate information concerning the Department's obligation under Title VI of the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973 which include Departmental Regulations, Statement of Compliance, and Method of Administration as well as training sessions, written material, meetings, notices and public announcements.

2. Maintain and review reports on initial and annual reviews of the Department's own operations, vendors, contractors, and other providers of services to assure compliance with Title VI and Section 504.

3. Receive and investigate all Title VI and Section 504 complaints from applicants, recipients, and other interested parties. When Title VI and Section 504 violations or deficiencies are validated, the Coordinator will assure prompt and corrective actions are taken. If compliance cannot be negotiated, the respective vendor, contractor, or other provider of service will be terminated from participation in the Department's program.

4. Act for the Department in Title VI and Section 504 matters with staff, other state agencies, local governments, providers or recipients of departmental program services, the general public and Federal agencies.

5. Assure that contracts or agreements are not negotiated with non-complying vendors such as doctors, hospitals, nursing homes, etc. Also, taking steps to assure that referrals are not made to noncomplying facilities, agencies, or other providers of service.

6. Apprise the Commissioner on a quarterly basis of all activities conducted and actions taken relative to Title VI and Section 504. The report will reflect the findings, actions required and results of the follow-up on each hospital, nursing home, physician's office review conducted during the quarter.

7. Maintain files and records relating to Title VI and Section 504.

C. **Title VI and Section 504 Reviewer**

The responsiblity, limitations and authority vested in this position include, but are not limited to, the following:

1. Disseminate the Department's non-discriminatory policy to all Department employees, doctors, hospitals, nursing homes, regional health offices, other contracted service agencies, and the general public.

2. Assure that all services and benefits of Federally assisted programs are not denied because of race, color, national origin or handicapped condition.

3. Make certain that complaint forms and procedures are available to vendors and contracted service agencies.

4. Review all complaints, whether received verbally or in writing and resolved or unresvoled, and prepare for disposition.

5. Conduct on-site reviews of designated facilities for Title VI and Section 504 compliance status.

D. **Regional Health Department Coordinator**

It shall be the responsiblity of the Regional Health Department Coordinator to assure that county and local health departments within their region are in compliance with Title VI and Section 504. The Title VI and Section 504 Coordinator will provide the necessary technical assistance, written material, notices, announcements and forms in order to effectively assure compliance of county and local health departments.

Each regional health department will have a designated Coordinator. The responsibility, limitations, and authority vested in this position includes, but are not limited to, the following:

1. Disseminate Title VI and Section 504 information to all local health department employees and clients;

2. Conduct on-site reviews annually on local health departments for Title VI and Section 504 compliance status. These reviews will be conducted by the Regional Coordinator.

3. Observe and assure that practices of the local health departments are in compliance with Title VI and Section 504 guidelines.

4. Orient staff in local health departments to Title VI and Section 504 regulations and responsibilities.

5. Assure that referrals for service are not made to facilities or individuals who are known to be in non-compliance with Title VI and Section 504.

6. Document that local health departments work with the public on a non-racial basis.

7. Transmit, in writing, all Title VI and Section 504 complaints to the Title VI/Section 504 Coordinator.

8. Complete periodic reports which will contain data applicable to Title VI and Section 504 compliance mat-

ters. This information shall be forwarded to the Title VI/Section 504 Coordinator on a monthly basis.

DISSEMINATION OF INFORMATION

The following methods will be utilized to advise Tennessee Department of Public Health employees, all local health department employees, applicants and recipients of services, and vendors apprised of the requirements of Title VI and Section 504 and all the rights and responsibilities that it assures:

INTERNAL:

1. An in-service training program for all Regional Health Department Coordinators with yearly maintenance technical assistance to be provided by the Title VI and Section 504 Coordinator.

2. An in-service training program concerning Title VI and Section 504 will be provided by the Regional Coordinator on a yearly basis to all new county and local health department employees.

3. The distribution of Title VI and Section 504 packets to all new employees. This information will be distributed during "New Employee Orientation" by the Division of Personnel, Recruitment and Training.

4. Training will be provided to any employee who has direct responsibility relative to Title VI and Section 504.

5. The distribution of the Department's non-discriminatory policy and posting the policy in a conspicuous place within all departmental facilities.

EXTERNAL:

1. Include in all contracts for service a Title VI and Section 504 policy statement.

2. Provide all information concerning the Tennessee Department of Public Health's non-discriminatory policy regarding Title VI and Section 504 to vendors, clients, recruiting sources and the general public as well as providing copies for all vendor facilities for posting.

3. Provide nursing homes, hospitals, physicians' offices and other contracted service facilities with policies, guidelines, complaint procedures and forms, brochures and other informational materials relative to Title VI and Section 504.

MAINTAINING AND ASSURING COMPLIANCE

The following methods will be utilized for maintaining and assuring compliance with Title VI and Section 504 in facilities receiving Federal financial assistance.

I. Regional Health Departments

Maintaining and assuring compliance in regional health departments will be accomplished in the following manner:

A. Each regional health department will have an assigned Regional Coordinator with the duties and responsibilities outlined in a previous section of this document.

B. On-site reviews will be completed by the Regional Coordinator annually for those local health departments within that region.

C. Quarterly reports will be completed by the Regional Coordinator which will contain data applicable to Title VI and Section 504 compliance status.

II. Hospitals and Clinics

Maintaining and assuring compliance for hospitals and clinics which receive Federal financial assistance through the Tennessee Department of Public Health will be accomplished in the following manner:

A. Annually hospital compliance information will be mailed to hospitals for completion and returned to the Department. The information will be reviewed for compliance purposes. If no questionable data is found, approval for compliance will be provided. If, however, questionable data is provided the Bureau of Medicaid Administration, Division of Health Care Facilities/Quality Assurance, will be requested to obtain specific data during their on-site reivew. (See Attachment I). Review findings will be forwarded to the Civil Rights Coordinator to ascertain compliance status. After review of the information, the facility will be requested to take steps to resolve all deficiencies or violations. The hospital must submit written documentation, within a pre-established time frame, to substantiate that corrective actions have been taken. If compliance issues cannot be corrected, compliance will not be granted and appropriate personnel, State agencies and OCR will be notified.

B. In those hospitals where Medicare and Medicaid compliance is necessary a joint effort between the Office for Civil Rights and the Tennessee Department of Public Health will be conducted. The Office for Civil Rights will conduct initial reviews of all hospitals which participate in Medicare and Medicaid. Compliance documentation of hospitals reviewed will be exchanged between the TDPH and OCR.

C. On-site and/or desk audits will be completed on those hospitals which are identified by complaints, violations or other pertinent information by the Department if the OCR has no current information on the matter.

D. If compliance issues cannot be resolved, State administered Federal funds will be withheld and/or contracts cancelled until compliance is agreed upon in writing. All appropriate personnel, State agencies and OCR will be notified of this matter by the Civil Rights Coordinator. The Department will provide a 120 day time frame in which facilities can respond, negotiate and resolve issues cited in the review.

III. Nursing Homes

Maintaining and assuring compliance for nursing homes which receive Federal financial assistance will be accomplished in the following manner:

A. Annually 20% of the nursing homes located in counties with more than 10% minority population and 5% of the nursing homes located in counties with less than 10% minority population will have on-site reviews conducted by the Bureau of Medicaid Administration, Division of Health Care Facilities/-Quality Assurance, during the regular review process. The team will be provided with a review form (See Attachment II) designed and approved by the OCR. Other information will be forwarded to the facility for completion prior to the on-site review. All information will be returned to the Civil Rights Coordinator by the team for review and response, and pending, compliance, or non-compliance status will be provided.

B. Annually nursing home compliance information will be mailed to the remaining 80% of the nursing homes for completion and returned to the Department. The information will be reviewed for compliance purposes. If no questionable data is found, approval for compliance will be provided. If, however, questionable data is provided, the facility will be requested

to take steps to resolve all deficiencies or violations. The facility must submit written documentation, within a pre-established time frame, to substantiate that corrective actions have been taken. If compliance issues cannot be resolved, State administered Federal funds will be withheld and/or contracts cancelled until compliance is agreed upon in writing. All appropriate personnel, State agencies and OCR will be notified of this mater by the Civil Rights Coordinator.

C. Title VI and Section 504 documentation on the review of nursing homes which jointly participate in Medicare and Medicaid will be exchanged between the Department and OCR.

D. On-site audits will be completed on those nursing homes which are indicated by complaints, reported violations or other information. The Department will provide a 120 day time frame in which facilities can respond, negotiate and resolve issues cited in the review.

IV. Physicians and Dentists

Maintaining and assuring compliance for physicians and dentists which receive Federal financial assistance will be accomplished in the following manner:

A. Information packets will be distributed to *all* physicians, dentists, and others of the healing arts that participate in the Medicaid program. The packet will include Title VI and Section 504 regulations, signs or posters indicating non-discriminatory policies and other pertinent information.

B. Annually 10% of the medical professionals who receive $25,000 and above will be reviewed for Title VI and Section 504 compliance.

C. A review of data from the "Surveillance and Utilization Review" provided by the Bureau of Medicaid Administration will be completed by the Civil Rights Coordinator on a quarterly basis. The review will identify provider, number of patients seen, number of visits per patient, number of patients hospitalized, kinds of medical services conducted, cost per service and other information. The information will be retrieved on providers which appear to have discrepancies in comparison to their medical counterparts and will be utilized for requiring an on-site audit by Medicaid program personnel or the Civil Rights Coordinator.

D. On-site and/or desk audits will be conducted when complaints, violations or other data indicate. If compliance issues cannot be resolved, State administered Federal funds will be withheld and/or contracts cancelled until compliance is met. Other State agencies and the OCR will be notified.

COMPLAINTS

The following methods will be utilized for handling Title VI and Section 504 complaints:

1. All information necessary for filing a complaint will be posted throughout the Department;

2. All information necessary for filing a complaint will be provided in pad form for those individuals who want to take the information with them. (See Attachment III).

3. Individuals who wish to file a complaint will be assisted in completing the required data if they so request;

4. Complaints may be resolved at the point where it is filed when filed verbally or in writing. However, a report or complaint, even if verbal, must be submitted in writing to the Department by the area receiving the complaint;

5. The Civil Rights Coordinator will investigate and resolve those complaints which are not handled at the originating point as indicated;

6. Complainants will be advised of the option of filing complaints with the Department, Regional Office, and/or the Regional Office for Civil Rights (Atlanta, Georgia).

7. Resolutions of complaints will be provided to the complainant;

8. All complaints will have an initial or preliminary investigation within at least 60 days after complaint is received;

9. A record of all complaints and their resolutions will be maintained by the Civil Rights Coordinator and will be available for review by the Office for Civil Rights upon request at any time during the Department's normal business hours;

10. The Department may request the complaint be investigated by other personnel when appropriate;

11. If complaints are valid and a Title VI or Section 504 compliance issue continues to exist, negotiations with those providers of service will be made by the Department in an effort to resolve the matter;

12. If complaints, which identify a valid Title VI compliance issue, cannot be resolved then the Department will take the appropriate action as outlined in the

MAINTAINING AND ASSURING COMPLIANCE section of this document;

13. The Department will advise the Office for Civil Rights of complaints which are received and of the action taken.

RECRUITMENT AND TRAINING

The Department will take the following action to assure that all recruitment and training programs of the Tennessee Department of Public Health are administered in such a way as to assure equal opportunity regardless of race, color, or national origin:

1. Assure that the AAP as adopted by the Department is being followed as well as assure that facilities receiving Federal financial assistance personnel policies are not discriminatory.

2. Review training and employment reports in an effort to ascertain minority participation.

3. Advise the Commissioner of the TDPH on any adverse action indicated through information obtained by observation.

PLAINTIFF'S EXHIBIT P-10

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office for Civil Rights

Region IV
101 Marietta Tower
Atlanta, GA 30323

November 21, 1980

Eugene W. Fowinkle, M.D.
Commissioner
Tennessee Department of Public Health
Bureal of Medicaid Administration and
Coordination
344 Cordell Hull Building
Nashville, Tennessee 37219

Complaint #04-80—3154

Dear Dr. Fowinkle:

As you know, the Office for Civil Rights (OCR) is in receipt of a complaint filed by Mr. Gordon Bonnyman of the Legal Services of Middle Tennessee, Inc. Mr. Bonnyman alleges that certain proposals to reduce services under the Medical Assistance Program under Title XIX of the Social Security Act will have an adverse effect upon minority and handicapped persons in violation of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973, respectively.

Pursuant to 45 C.F.R. §80.7 of the regulations promulgated under Title VI of the Civil Rights Act and 45 C.F.R. §84.61 of the regulations promulgated under Section 504 of the Rehabilitation Act, OCR must conduct a prompt investigation of this complaint. To that end, the enclosed data request is submitted for your review and completion.

The data request was designed after consultation with the Health Care Financing Administration and is compatible with data available through the Tennessee Medicaid Management Information System (MMIS). In order to clarify and respond to any question you may have regarding the data request, we would like the opportunity to meet with you within the next ten (10) days. We request that the meeting also include members of your staff and representatives from the fiscal intermediary, Electronic Data System Federal Corporation, who are familiar with the MMIS. Ms. Narris Kennebrew of my staff will be contacting you to arrange a meeting date and time.

The state's response to the OCR data request must be forwarded to Ms. Marie Chretien, Division Director, no later than 30 days after the meeting to be scheduled between our two staffs.

Your cooperation in this matter is appreciated. Should you have any questions, do not hesitate to contact either Ms. Marie Chretien, Division Director, or Ms. Narris Kennebrew, Equal Opportunity Specialist, at (404) 221-5962.

Sincerely yours,

/s/ Carolyn J. Russell
Regional Director
Office for Civil Rights

DATA REQUEST

The Office for Civil Rights has obtained a copy of the state's current "State Plan for Medicaid Assistance Plan Under Title XIX of the Social Security Act," as well as state plan materials which were obsoleted during 1978, 1979 and 1980. These materials were obtained from the regional office of the Health Care Financing Administration. In responding to this data request, where appropriate, please specify the pertinent section of the state plan, including the effective date of the relevant section.

1. Please provide a description of the following:

   a. **Number of Medicaid Eligibles by Eligibility Category By Race and By Handicap***: For fiscal year 1980 describe the number of Medicaid eligibles by race, by handicap and by type of eligibility category. For each such type and category, describe any changes in eligibility standards during fiscal year 1980. The term eligibility standard includes changes in income limits, resource limits, or bases of deprivation under the AFDC program.

   b. **Scope of Services:** List all mandatory and optional services included in the state Medicaid Program, and indicate whether it is available to the categorically needy and/or medically needy. For each such service describe the present scope of said service, as well as any additions, deletions, or limitations imposed on each such service during fiscal year 1980.

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* For purposes of this data request, the term "handicap" refers to the following categories: those individuals who are eligible for the Medicaid program because they are either (1) blind or (2) disabled, or have a physical or mental handicap or disability such as (3) ~~these persons receiving drug and alcohol treatment, or~~ (4) those persons in ICFs *or SNFs over age 65* and (5) ~~handicapped~~ children, *under 21 in ICF-MRs,* ~~identified under the EPSDT program.~~

With regard to Medicaid services provided under the drug formulary, indicate whether the state has imposed a limit on the number of refills, or a minimum or maximum quantity which may be received by a beneficiary for (i) beneficiaries residing in an ICF and (ii) other beneficiaries.

c. **Reimbursement:** For each service set forth in your response to question 1b, describe the present level and methodology for providing remibursement for each such service, as well as any changes in either the level or methodology which occurred during fiscal year 1980. Has the state made any determination of the extent to which its level of reimbursement for each such service is sufficient to provide Medicaid recipients with access to each such service at least equivalent to that enjoyed by the general population? If the answer to the foregoing question is in the affirmative, then provide any documentation which supports such a determination.

d. **Administration:**

(i) For each such service identified in question 1b, is the service presently subject to prior authorization? If the answer to the foregoing question is in the affirmative, describe the present prior authorization procedure applicable to each such service, as well as changes implemented during fiscal year 1980. Identify by race and handicap the number of persons subject to the prior authorization requirement during each month in fiscal year 1980.

(ii) During fiscal year 1980, did the state use a lock-in procedure for Medicaid recipients? If the answer to the foregoing question is in the affirmative, describe the lock-in procedure, as well as changes implemented during fiscal year 1980.

Identify by race and handicap the number of persons subject to lock-in during each month in fiscal year 1980.

(iii) For each of the services identified in question 1b,is the service presently subject to a post-service review? If the answer to the foregoing question is in the affirmative, describe the present post-service review procedure applicable to each such service. Identify any changes in the post service review procedure applicable to each such service in fiscal year 1980. Identify by race and handicap the number of persons subject to the post-service review during each month in fiscal year 1980.

2. Please describe each proposed Medicaid reduction to be implemented in fiscal year 1980-81. The description should include, but is not limited to the following:

(a) **Scope of Services:** For each type and category of service scheduled for reduction, describe the scope of services to be provided under the proposal; as well as any deletions, additions, or limits to be imposed.

(b) **Reimbursement:** For each service set forth in your response to question 2a, describe the level and methodology which will be used to determine reimbursement for each such service. Has the state determined the extent to which this level of reimbursement will sufficiently provide Medicaid beneficiaries with access to each such service at least equivalent to that enjoyed by the general population? If the answer to the foregoing question is in the affirmative, please provide any documentation which supports such a determination.

(c) **Administration:** For each such service identified in question 2a, will said service be subject to a prior authorization, lock-in, or post-service review procedure? If the answer to any part of the foregoing question is in the affirmative, describe the procedure.

3. (a) With regard to each reduction set forth in question 2(a), please state the objective to be served by they proposed reduction in service. If the objective is fiscal savings, please specify for each proposed reduction the amount to be saved and the time period over which said savings will be realized.

(b) When was the decision made to implement the proposed reductions? By whom? Are there reports, memorandums, minutes of meetings, or other documents regarding how the decision was made? If so, please specify and provide copies.

(c) What factors were considered and what conclusions were reached?

(d) Did the Tennessee Department of Public Health, or any other agency or empioyee of the state of Tennessee consider the effects of the proposed reduction in services on minorities and handicapped persons? If so, what were the findings? What methodology was utilized to project the effects? When were the findings made? Were any written reports generated by these findings? If the answer to any of the foregoing is in the affirmative, please specify and provide copies.

(e) What options were considered for changes other than those specified proposals set forth in question two above. For each option, state why the option was rejected, and the extent to which implementation would have realized the objective set forth in answer to question 3a.

4. (a) For each of the following Medicaid services: inpatient services, outpatient services, emergency care services, clinic services, and physician's services provided in a physician's office, complete the attached tables* requesting beneficiary utilization data of services for fiscal year 1980 by county**, for the state, by race and by handicap.

   (b) For fiscal year 1980, indicate by race the number of Medicaid eligibles who were 65 years of age or older.

5. For fiscal year 1980, please provide the following data by completing chart 6:

   (a) The total number of beneficiaries by race and by specified county who have and for the state who have been certified for ICF admission.

   (b) Of those persons certified, the number of beneficiaries by race and by county who:

      (i) have been admitted to ICF's;
      (ii) are in board and care facilities;
      (iii) are receiving home health services;
      (iv) are receiving other services; or
      (v) are receiving no services.

6. Of those persons certified and currently in ICF's, how many beneficiaries by race and on a statewide basis are:

      (i) categorically needy; and
      (ii) medically needy Medicaid beneficiaries.

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* Inpatient services, chart #1 and #1(a); outpatient services, chart #2 through #2(c); emergency care services, chart #3 and #3(a); clinic services, chart #4 and #4(a); and physician's services provided in a physician's office, chart #5 and #5(a).

** For purposes of this data request, data by county will be requested for only Davidson, Hamilton, Knox, Shelby and Sullivan Counties.

7. For fiscal year 1980, indicate for each drug proposed to be deleted in the formulary the number of Medicaid beneficiaries by race and handicap who received each such drug, the quantity received, and amount expended in each drug category.

8. For each drug proposed to be eliminated from the drug formulary, identify the alternative drug or service the state has determined may be substituted.

9. Please indicate:

   (a) The number of physicians in active practice in the state;

   (b) The number of physicians participating in the Medicaid program;

   (c) By county, the number of physicians who have submitted the number of claims specified in chart #7 for services rendered in a physician's ofice.

10. The Office for Civil Rights has obtained a copy of the state agency's current Title VI Methods of Administration Plan. Please describe any changes which may have been adopted since its submission to this office in April 1980.

11. Describe all efforts undertaken to implement the Title VI Methods of Administration, particularly with regard to the monitoring of skilled nursing and intermediate care facilities and nursing home utilization. When were these efforts taken and what were the results?

12. Please provide a copy of the current claims form used by providers to bill the state for medical services, and provide copies of any other versions of the claims form that were in effect during fiscal year 1980.

EDITOR'S NOTE

PAGES 154 through 167 WERE POOR HARD COPY AT THE TIME OF FILMLNG. IF AND WHEN A BETTER COPY CAN BE OBTAINED, A NEW FICHE WILL BE ISSUED.

Chart 1: Total Number of Inpatients Per Beneficiary By Race and By County for Fiscal 1980

		RACE			
COUNTY		Black	White	Other	Total
Davidson	Number of Inpatient Days Per Year				
	1-14				
	15-20				
	21 or more				
	TOTAL				
Hamilton	1-14				
	15-20				
	21 or more				
	TOTAL				
Knox	1-14				
	15-20				
	21 or more				
	TOTAL				
Shelby	1-14				
	15-20				
	21 or more				
	TOTAL				
Sullivan	1-14				
	15-20				
	21 or more				
	TOTAL				
Statewide (95 County) Total	1-14				
	15-20				
	21 or more				
	TOTAL				

Handicap for Fiscal Year

COUNTY		HANDICAP. Blind	Disabled	Drug and Alcohol	Handicapped Children.	Other (Please Specify)	TOTAL
	Number of Inpatient Days Per Year						
	1-14						
Davidson	15-20						
	21 or more						
	TOTAL						
	1-14						
Hamilton	15-20						
	21 or more						
	TOTAL						
	1-14						
Knox	15-20						
	21 or more						
	TOTAL						
	1-14						
Shelby	15-20						
	21 or more						
	TOTAL						
	1-14						
Sullivan	15-20						
	21 or more						
	TOTAL						
	1-14						
Statewide (95 County) Total	15-20						
	21 or more						
	TOTAL						

PLAINTIFF'S EXHIBIT P-24

Health Characteristics Of Persons With Chronic Activity Limitation

United States 1974

Table 9. Number of hospital days and average length of stay for discharges from short-stay hospitals, by chronic activity limitation status, sex, and age: United States, based on data collected in health interviews in 1974

Sex and age	Total population	With no limitation of activity	With limitation of activity			
			Total	Limited but not in major activity[1]	Limited in amount or kind of major activity[1]	Unable to carry on major activity[1]
	Number of hospital days in thousands					
Both sexes						
All ages	248,345	109,807	138,408	12,717	52,066	71,625
Under 17 years	38,313	18,588	9,726	*	1,088	3,809
17-44 years	82,148	49,317	32,832	3,712	14,586	14,166
45-64 years	76,318	28,454	48,866	4,487	30,581	34,427
65 years and over	81,565	13,579	47,566	3,719	15,042	20,226
Male						
All ages	118,890	43,070	75,819	5,419	18,874	50,326
Under 17 years	18,620	11,397	4,223	*	*	2,226
17-44 years	30,880	14,384	16,496	1,430	5,893	9,163
45-64 years	43,982	12,087	31,896	3,074	9,809	20,173
65 years and over	38,267	5,183	33,084	1,816	3,743	17,525
Female						
All ages	129,896	66,837	60,799	7,298	32,193	21,206
Under 17 years	9,693	8,190	1,502	*	*	5,042
17-44 years	51,269	34,933	16,376	2,281	9,022	4,253
45-64 years	32,346	14,357	18,009	2,303	11,272	11,400
65 years and over	33,296	8,396	24,902	2,303	11,299	
	Average length of stay in days					
Both sexes						
All ages	8.4	8.9	12.4	8.7	10.2	16.2
Under 17 years	8.7	4.8	12.1	*	8.3	30.8
17-44 years	8.8	8.3	11.8	8.8	10.8	19.2
45-64 years	10.2	7.8	13.8	8.8	10.8	16.1
65 years and over	11.7	8.2	12.7	11.8	10.8	14.3
Male						
All ages	8.8	8.4	14.1	8.2	11.2	16.8
Under 17 years	8.5	8.3	17.1	*	*	47.4
17-44 years	8.8	8.8	14.3	7.1	11.8	21.1
45-64 years	11.8	7.8	14.7	8.3	13.4	17.3
65 years and over	11.7	8.8	12.8	14.4	10.3	13.3
Female						
All ages	7.4	8.7	10.8	8.3	8.7	14.8
Under 17 years	4.8	4.8	8.8	*	*	*
17-44 years	8.8	8.1	10.1	8.8	8.3	16.8
45-64 years	8.8	7.2	10.8	8.8	8.4	12.1
65 years and over	11.8	8.8	12.8	10.1	10.7	16.8

[1] Major activity refers to ability to work, keep house, or engage in school or preschool activities.

PLAINTIFF'S EXHIBIT P-25

Characteristics, Social Contacts, and Activities of Nursing Home Residents

United States
1973-74 National Nursing Home Survey

Figure 1. Percent of nursing home residents by sex, age, and marital status: United States, 1973-74

paring nursing home residents to the noninstitutionalized population. Nursing home residents are an elderly population; most (89 percent) were 65 years of age or older, and 38 percent were 85 years of age or older (table 1). The mean age for residents was 79.

Another characteristic of nursing home residents which was similar to that found in earlier surveys is the large proportion of widows and widowers. A greater proportion of the residents were widowed than were married, divorced, separated, or never married. Furthermore, between the ages of 65 and 90 the proportion of residents who were widowed increased directly with age. From age 90 the proportion of nursing home residents who were widowed leveled off. An important distinction, however, is found when marital status of male and female residents is compared—75 percent of the women were widowed compared to only 42 percent of the men. From the opposite point of view, only 8 percent of the women had a living spouse who could presumably visit them or be responsible for them away from the facility, while 22 percent of the men had a living spouse.

When marital status is examined by characteristics of the facility, there are differences by region and certification status. A somewhat greater proportion of residents living in facilities in the Northeast and North Central Regions than of those living in the South or West had never been married. Also, a greater proportion of those in uncertified facilities than of those in certified facilities had never been married (table 2).

Race or Ethnicity

The 1973-74 National Nursing Home Survey shows greater detail on race or ethnicity than the earlier NCHS surveys did. The question on resident's race or ethnicity was as follows:

What is (name) ethnic background? (Mark (X) only one box)

- ☐ Caucasian
- ☐ Negro
- ☐ Oriental
- ☐ Spanish American
- ☐ American Indian
- ☐ Other

Only one answer category was permitted for each resident. Because of this feature of the questionnaire, racial background of the Spanish American residents was not obtained. Therefore in this report "white" refers exclusively to those residents for whom the category "Caucasian" was checked. Whenever cell size permits, detail on the other racial or ethnic groups is shown separately.

Table A shows the number of nursing home residents by racial or ethnic group. Most of the residents were white (excluding Spanish Americans), which is true of the American population

Table A. Number and percent of nursing home residents by race or ethnicity: United States, 1973-74

Race or ethnicity	Number	Percent
All residents	1,079,800	100.0
White[1]	1,018,400	93.9
Black	48,300	4.8
Spanish American	13,000	1.1
Other	4,200	0.4

[1] Excludes Spanish American.

PLAINTIFF'S EXHIBIT P-26

DATA ON THE MEDICAID PROGRAM: ELIGIBILITY, SERVICES, EXPENDITURES

1979 EDITION
(Revised)

Medicaid/Medicare Management Institute

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration
Baltimore MD 21235
1979

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX, JANUARY, 1979

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
[illegible]	30 days per calendar year	Preauthorization required	Preauthorization required	1 visit per month elsewhere for chronic stable illness; 1 visit per day in hospital.
[illegible]	Nonemergency out-of-State hospitalization requires preauthorization.	Preauthorization required	Preauthorization required	Elective (cosmetic) surgery requires preauthorization.
[illegible]	Limited to 30 days per calendar year with provision for extension based on medical necessity and with prior authorization.	Prior authorization required	No limitations	18 visits per calendar year in physician's office, patient's home or nursing home. For hospital emergency room visits, 12 per calendar year.
[illegible]	Subject to prior authorization and specified length of stay as approved.	Subject to preadmission authorization and periodic reauthorization.	Subject to preadmission authorization and periodic reauthorization.	Subject to prior authorization for more than eight psychiatric visits or eight allergy hyposensitization visits in a 120-day period. Services for cosmetic purposes not covered. Prior authorization required for sterilization services.
[illegible]	Services provided as long as is medically necessary. Emergency hospital services provided when necessary to prevent death or serious impairment of health, even though hospital may not meet conditions for participation under Title XVIII.	No limitations	No limitations	No limitations.
[illegible]	Prior authorization is required beyond 10 days.	Initial review to determine level of care made by a medical consultant within 14 days of patient's admission to a facility. Periodic patient reviews are made thereafter by a team to determine continued need for skilled nursing services.	Level of care is determined within 14 days of patient's admission to facility and the need for continued care in the facility is periodically redetermined thereafter.	Prior authorization required for services to patients in skilled nursing facilities beyond 1 visit per month for chronic conditions and 5 visits per month for acute conditions.
[illegible]	No limitations	No limitations	No limitations	No limitations.

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX—Continued

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
North Carolina	Prior authorization required for admissions for cosmetic surgery and surgical transplants except bone, tendon and renal transplants.	Prior approval required	Prior authorization required	Routine physical exams and routine screening tests are excluded except for EPSDT recipients and an annual examination allowed for recipients in homes for aged, skilled nursing and intermediate care facilities. Eye refractions are limited to 1 per year for recipients ages 24 and under, and 1 in 2 years for recipients ages 25 and over. Prior approval required for surgical transplants (except for bone, renal and tendon),, cosmetic surgery and more than 2 psychiatric visits.
North Dakota	No limitations	No limitations	No limitations	No limitations.
* Ohio	60-day limitation per spell of illness .	Physicians' certification and recertification required every 60 days.	No limitations. Persons must be in need of such care.	10 physician visits per month.
* Oklahoma	10 days per admission	Prior approval required	Preauthorization required	Limited to inpatient hospital visits and surgical services for a compensable hospital period; outpatient-4 office visits and/or 4 home visits per month per patient; and 2 visits per month in a nursing home.
Oregon	Limited to 21 days	No limitations	No limitations	Prior authorization required for elective and rehabilitative procedures.
Pennsylvania	Payment is not made for overnight or weekend passes in excess of 12 hours continuous absence and absence for purposes of employment or school. Payment is not made for prolonged hospitalization which is not medically justified.	No limitations	No limitations	Prior authorization required for all general and special medical examinations and consultations. Hospital inpatients—consultations limited to 1 per specialty per hospital admission; outpatient—consultation limited to 1 per 12 month period. $200 maximum amount payable to physician for his services provided during any 1 period of hospitalization or for a series of recurrent or related surgical procedures.

Puerto Rico	Limited to services provided in public facilities and 2 private facilities under contract.	Provided in public facilities	Not provided	Available through public facilities and some physicians under contract.
Rhode Island	Prior authorization required for stays in excess of 15 days per admission for persons under age 65, or in excess of 60 days for persons age 65 or older who are also covered by Medicare.	Prior authorization required for all admissions.	No limitations	Prior authorization required for visits in excess of 2 per month for chronic illness and in excess of 8 per month for acute illness; inpatient hospital visits in excess of 37 days up to maximum of 100 days, office visits provided by psychiatrists beyond initial evaluation visit.
South Carolina	40 days per Fiscal Year	Need for care approved or disapproved by PSRO.	Need for care approved or disapproved by PSRO.	Visits must be medically justified.
South Dakota	30 days per benefit period. 1st 3 pints of blood per benefit period.	No limitations	No limitations	Limited to services which are medically necessary and required by patient.
Tennessee	20 days per Fiscal Year	Prior authorization required	No limitations	Prior approval required for unusual elective types of surgical procedures.
Texas	30 days per spell of illness	Level of care determination is required	Level of care determination is required	No limitations.
Utah	No limitations	No limitations	No limitations	No limitations on number of visits for acute conditions, except psychiatric care is limited to 12 hours of treatment for each acute illness unless prior written approval for additional care is obtained.
Vermont	No specified day limitations	Authorization is required	Authorization is required	Treatment of mental, psychoneurotic or personality disorders limited to $500 per calendar year.
Virgin Islands	Prior authorization required	Service presently being developed. Prior authorization will be required.	Not provided	Limited to services provided by Health Department personnel; otherwise by prior authorization of the Bureau.

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX—Continued

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
Kansas	All out-of-State inpatient care is subject to prior authorization except for emergency care and care within hospitals bordering Kansas, whose services are routinely utilized by Kansas recipients. No payment will be made for inpatient admissions from midnight Thursday through midnight Saturday except in the case of an emergency admission.	No limitations	No limitations	Office calls are limited to 3 per month unless supported by written documentation confirming medical necessity. Adult care home visits are limited to 1 per month unless supported by written documentation confirming medical necessity. Surgery for cosmetic purposes is not payable. Abortions are provided when necessary because the life of the mother is endangered if the fetus is carried to term, or when performed upon a victim of rape or incest and it has been reported to appropriate authorities within 60 days of the incident.
Kentucky	21 days per admission	Preauthorization required	Preauthorization required	Initial and extensive visits limited to 2 per patient per physician per calendar year. Preauthorization required for those patients "locked in" to 1 physician and 1 pharmacy, who require services in excess of 4 prescriptions and 4 physician office visits per month.
Louisiana	Care in a short term general hospital is limited to 15 days in a calendar year without prior approval. If a recipient requires hospitalization beyond 15 days, or readmission only when medically necessary home passes are required, a determination to extend hospitalization would be made.	No limitations	No limitations	Limited to 12 outpatient visits per year, with extensions subject to prior approval. Up to 15 inpatient visits including admission visits in any calendar year when recipient is hospitalized without surgery.
Maine	Prior authorization required for extension of hospital benefit days beyond 60 days. Intensive care and coronary care services do not require prior authorization.	No limitations	No limitations	No limitations.

Maryland	Preauthorization required	Preauthorization required for all initial nursing home admissions.	Preauthorization required for all admissions.	Preauthorization required for surgery normally considered cosmetic.
Massachusetts	No limitations	No limitations	No limitations	Preauthorization required.
Michigan	Minimum period necessary in type of facility for the proper care and treatment of patient.	Minimum period necessary in type of facility for the proper care and treatment of patient.	Provided based on level of care appropriate to patient's medical needs.	Visits in the nursing home setting are limited to 1 visit per patient per month; additional visits must be documented as medically necessary.
Minnesota	No limitations	No limitations	No limitations	No limitations.
Mississippi	40 days per Fiscal Year	Prior authorization required	Prior authorization required	Hospital visits—limited to 1 per day; nursing home visits—limited to 36 per Fiscal Year.
Missouri	21 days per admission	Prior authorization required	Prior authorization required	Limited to those that are medically necessary. Payment is not made for cosmetic surgery. Certain recipients who have over-utilized physician's services are limited to service of only 1 physician of their own choosing.
Montana	No limitations	No limitations	No limitations	No limitations.
Nebraska	Prior authorization required	No limitations	No limitations	No specified limitations.
Nevada	Limited to admissions designated in the Concurrent Review Screening manual.	Prior authorization required	Prior authorization required	Limited to 2 office visits per person per month for treatment of illness, 2 therapeutic injections per month and emergency treatment. Services to hospital inpatients are not limited.
New Hampshire	Requires prior approval for patients who are anticipated to require hospitalization for period longer than 12 days.	Prior authorization required	Prior authorization required	Limited to 1 visit per month per patient, except 1 visit per week for acute care SNF patients.
New Jersey	Limited by exclusion of elective cosmetic surgery and diet therapy for exogenous obesity.	Prior authorization required except where patient is transferred to nursing home directly from an acute care facility.	Prior authorization required	Prior authorization required for elective cosmetic surgery and podiatric treatment when costs exceed $300 in given year.
New Mexico	Abortions are provided under certain conditions.	No limitations	No limitations	Abortions are provided under certain conditions.
New York	No limitations	Prior approval except when admitted directly from hospital, another nursing home, or from health related facility.	No limitations	No limitations.

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX—Continued

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
District of Columbia	Services provided in connection with surgical procedures for cosmetic purposes (except for emergency repair of accidental injury) will be included only by prior authorization issued by State agency. services provided in connection with dental or oral surgery will be limited to those required for emergency repair of accidental injury to jaw and related structures.	Items and services furnished by skilled nursing facilities maintained primarily for care and treatment of inpatients with TB will be provided only for individuals 65 years of age or older.	No limitations	Elective procedures requiring general anesthesia will be provided only when performed in a facility accredited for such procedures. Surgical procedures for cosmetic purposes (except for emergency repair of accidental injury) will be provided only by prior authorization issued by State agency. Ambulatory psychiatric care will be provided only in a formally organized psychiatric clinic which is approved as such by State agency, except when prior authorization for such care has been obtained from State agency.
Florida	45 days per patient per Fiscal Year	No limitations	No limitations	Excludes routine physicals and eye examinations, internal organ transplants which are considered experimental, clinically unproven procedures, and sterilization procedures for any person who has been judicially declared mentally incompetent, or who is under age 21, or who is legally incompetent under State law.
Georgia	Prior approval required for renal dialysis and/or kidney transplants except in cases of emergency dialysis.	Initial prior approval is required	Initial prior approval is required	Outpatient psychotherapy is limited to maximum of $250 per patient per calendar year. Unless medically justifiable need for exception exists, home and office visits limited to 1 per month, nursing home visits limited to 1 per month, and hospital visits limited to 1 per day.
Guam	A Medicaid recipient may not be confined for more than 65 consecutive days at a semi-private rate. If confinement is medically necessary after this period of time, then a reduced room rate equal to a SNF must be utilized. Only first 3 pints of blood. One doctor visit per day except for intensive care or consultation.	Limited to 3 routine Doctor's visits per month. Cost and limitations as outlined in Title XVIII.	Not provided	2 visits per week in SNF. Transportation cost of physician not covered.

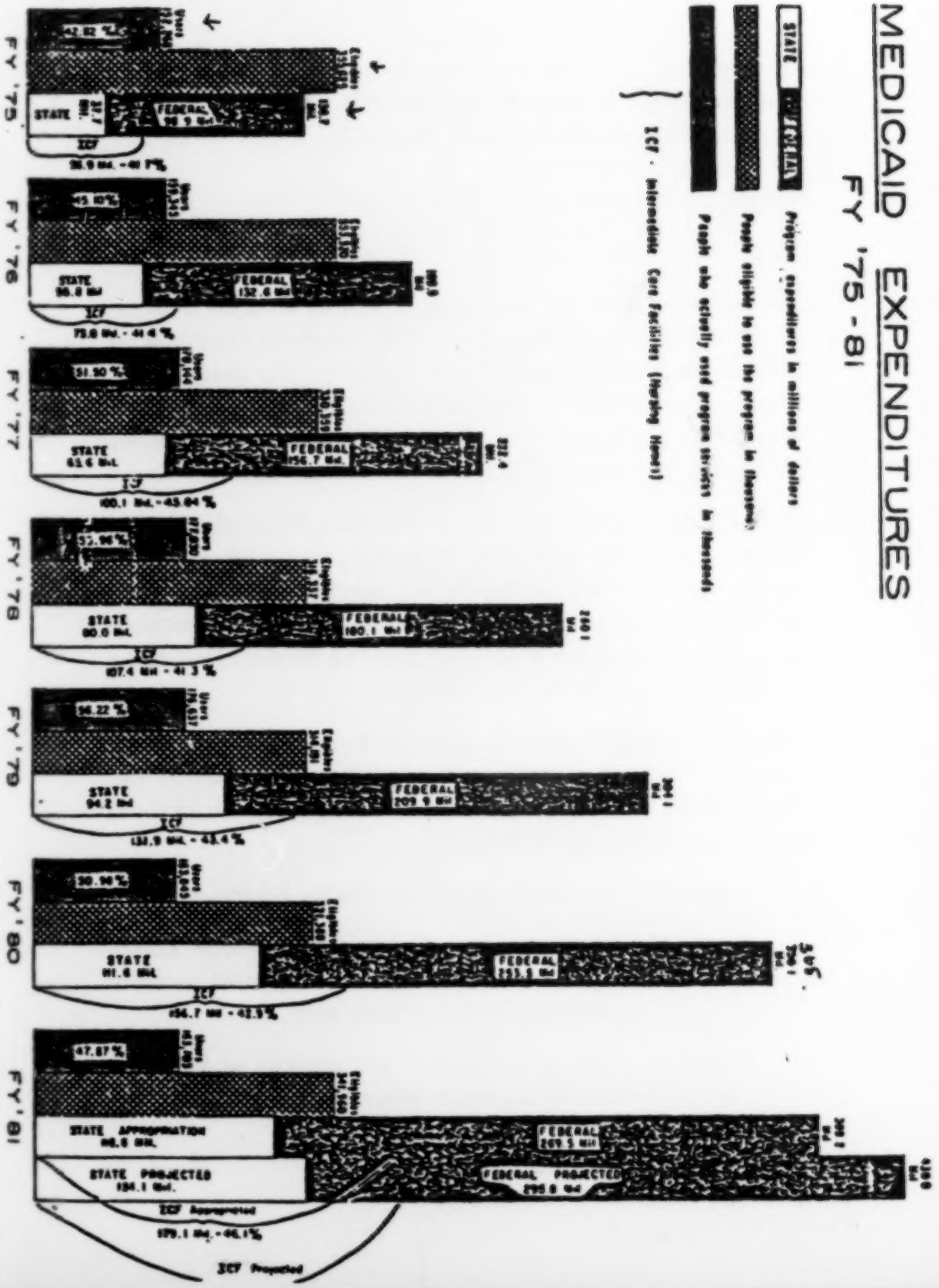
Hawaii	Hospital admissions are authorized for following number of days: Medical and surgical—8 days. Confinement and delivery—4 days. T. & A.—2 days. Psychiatric—10 days. Prior authorization is required for any non-emergency admission such as for elective surgery; approval for extension is required for additional days.	Prior authorization required	Prior authorization required	For patients in skilled nursing facilities limited to 2 visits per month except during acute episodes when additional visits are authorized.
Idaho	Limited to 40 days per admission. Length of stay subject to professional review for appropriateness and necessity, but will not exceed forty days per admission.	Prior authorization is required before payment.	Prior authorization is required before payment.	Physician services related to abortion or abortion related services will not be provided unless the abortion or abortion related services are recommended by 2 consulting physicians who state that it is necessary to save the life of the mother, 2 consulting physicians' recommendations that the mother will suffer severe and long lasting physical health damage if the fetus is carried to term; that in the case of rape or incest, the incident is reported promptly to a law enforcement agency or public health agency and the pregnancy is a result of rape or incest as determined by the court.
Illinois	Psychiatric services limited to an initial period of 10 days and a possible 10 day extension with prior approval. There is a maximum of 45 inpatient days per year.	No limitations	No limitations	No limitations.
Indiana	No limitations	No limitations	No limitations	No limitations.
Iowa	No limitations	No limitations	No limitations	No limitations.

TABLE 2.—LIMITATIONS ON SELECTED SERVICES OFFERED UNDER TITLE XIX—Continued

State	Inpatient Hospital Services	Skilled Nursing Facility Services	Intermediate Care Facility Services	Physicians' Services
Virginia	14 days per admission	No limitations	No limitations	Cosmetic surgical procedures are not covered unless performed for physiological reasons. Routine physicals and immunizations are not covered except that well-child examinations in a private physician's office are covered for foster children. Prior authorization is required for refraction and eyeglasses. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health to the mother if the fetus were carried to term. Substantial endangerment of health includes endangerment of the life of the mother.
Washington	Admission and length of stay determined by PSRO.	Prior approval of admission	No limitations	1 visit per month in office, home, skilled nursing facility, and intermediate care facility. 2 per month in extended care facility. 1 per day in hospital, additional calls must be justified.
West Virginia	60 days per Fiscal Year	Prior approval of admission	Prior approval required	No limitations.
Wisconsin	Prior authorization is required for cosmetic surgery, intestinal or gastric bypass surgery and reversal of a tubal ligation or vasectomy.	Prior authorization required	Prior authorization required	Prior authorization is required for cosmetic surgery, intestinal or gastric bypass surgery and reversal of a tubal ligation or vasectomy.
Wyoming	14 days per spell of illness	No limitations	No limitations	Physical examinations limited to 1 yearly after 3rd year of life; nursing home visits limited to 1 routine visit per month.

DEFENDANTS' EXHIBIT

D- 2



DEFENDANTS' EXHIBIT D-4

February 12, 1981

Mr. Ben C. Crim, Assistant Commissioner
Medicaid Administration & Coordination
Tennessee Department of Public Health
283 Plus Park Boulevard
Nashville, Tennessee 37217

Dear Ben:

Attached are Tables 1, 2 and 3 which provide an analysis of inpatient utilization and the impact of the proposed limitation on users of inpatient services. For purposes of this analysis, the utilization of services by Medicare Medicaid patients has been included since any utilization of services by these people will not be affected bya proposed limitation on patient days.

Table 4 is an analysis of the impact on patient days utilization of the proposed 14 day limitation on the total Medicaid user community. Tables 5 and 6 are the patient days analysis for minority and handicapped patient days users. The utilization of services by recipients who have both Medicare and Medicaid coverage has not been included in these tables.

Tables 7, 8 and 9 were used to determine the number of Medicare Medicaid users. I have also enclosed copies of the reports which provided the source of the information in these tables. The reports are as follows:

Report A: Medically and Categorically Needy

Report B: Medically and Categorically Needy Usage Analysis for *Acute* Care Medicaid patients only by number of days used

Report C: The total pages of the analysis of inpatient utilization which includes psychiatric services but excluded crossovers.

Report A, which is the beginning point of this analysis, balances to MARS report HMGR543 for inpatient category of service.

Sincerely,

William B. Shaw
Program Director

WBS/js

enclosures

DEFENDANTS' EXHIBIT D-4(a)

Table 1

INPATIENT USAGE ANALYSIS
ALL USERS FY 79/80

No. Days Utilized	Medicaid Med. Needy	Medicaid Categ. Needy	Total	Cumul. Users Affected	% Users Served
0	100	23	123	-	-
1	3672	637	4309	-	-
2	8108	881	8989	-	-
3	6321	775	7096	-	-
4	4212	516	4728	-	-
5	3276	496	3772	-	-
6	2731	407	3138	-	-
7	2239	352	2591	-	-
8	1731	304	2035	-	-
9	1323	290	1613	-	-
10	1181	243	1424	-	-
11	975	200	1175	-	-
12	839	180	1019	-	-
13	780	145	925	-	-
14	696	158	854	7279	92.56
15	565	120	685	6594	93.27
16	568	119	687	5907	93.97
17	482	123	605	5302	94.59
18	433	101	534	4768	95.14
19	389	106	495	4273	95.64
20	3320	953	4273	-	-
	43941	7129	51070		
Medicare	-	-	47051		
Medicaid					
Grand Total Users			98121		

(% Users Served = Total Users - Cumul. Users Affected / Total Users

DEFENDANTS' EXHIBIT D-4(b)

Table 2

INPATIENT USAGE ANALYSIS
MINORITY FY 79/80

No. Days Utilized	Minority Users Black	Other	Total Minor. Users	% Minor. Users Served	Cumul. Users Affected
0 - 13	17611	494	18105	-	-
14	262	17	279	93.25	2248
15	193	16	209	93.88	2039
16	214	20	234	94.58	1805
17	175	17	192	95.10	1613
18	146	15	161	95.64	1452
19	139	11	150	96.09	1302
20	1186	116	1302	-	-
	19926	706	20632		
Medicare/Medicaid	11302	1419	12721		
Grand Total			33353		

$$\% \text{ Minority Users Served} = \frac{\text{Grand Total - Cumul. Users Affected}}{\text{Grand Total}}$$

DEFENDANTS' EXHIBIT D-4(c)

Table 3

INPATIENT USAGE ANALYSIS
HANDICAP FY 79/80

No. Days Utilized	Handicapped Users Disabled	Blind	Total Handicapped Users	% Handicapped Served	Cumul. Users Affected
0 - 13	11511	253	11764	-	-
14	458	13	471	84.40	4617
15	385	8	393	85.73	4224
16	382	7	389	87.04	3835
17	349	5	354	88.24	3481
18	320	8	328	89.35	3153
19	304	5	309	90.39	2844
20	2804	40	2844	-	-
	16513	339	16852		
Medicare/ Medicaid	12169	588	12757		
Grand Total Handicapped Served	28682	927	29609	-	

$$\% \text{ Handicapped Served} = \frac{\text{Total Handicapped Users - Cumul. Users Affected}}{\text{Total Handicapped Users}}$$

DEFENDANTS' EXHIBIT D-4(d)

Table 4

PATIENT DAYS IMPACT ANALYSIS
ALL USERS FY 79/80

No. Days Utilized	Total Patient Days	Users Affected	Patient Days Cutback (14 Day Limit)
0	-	-	-
1	4,309	-	-
2	17,978	-	-
3	21,288	-	-
4	18,912	-	-
5	18,860	-	-
6	18,828	-	-
7	18,137	-	-
8	16,280	-	-
9	14,517	-	-
10	14,240	-	-
11	12,925	-	-
12	12,228	-	-
13	12,025	-	-
14	11,956	-	-
15	10,275	685	685
16	10,992	687	1,374
17	10,285	605	1,815
18	9,612	534	2,136
19	9,405	495	2,475
20	85,460	4,273	25,638
Total Days:	348,512	Cutback Days:	34,123

$$\% \text{ Days Cutback} = \frac{\text{Pat. Days Cutback}}{\text{Total Patient Days}} = \frac{34,123}{348,512} = 9.79\%$$

DEFENDANTS' EXHIBIT D-4(e)

Table 5

PATIENT DAYS IMPACT ANALYSIS
MINORITY USERS FY 79/80

No. Days Utilized	Total Patient Days	Users Affected	Patient Days Cutback (14 Day Limitation)
1 - 13	80,437	-	-
14	3,906	-	-
15	3,135	209	209
16	3,744	234	468
17	3,264	192	576
18	2,898	161	644
19	2,850	150	750
20	26,040	1,302	7,812
Total Days:	126,274	Cutback Days:	10,457

$$\% \text{ Days Cutback} = \frac{\text{Pat. Days Cutback}}{\text{Total Patient Days}} = \frac{10,457}{126,274} = 8.28\%$$

DEFENDANTS' EXHIBIT D-4(f)

Table 6

PATIENT DAYS IMPACT ANALYSIS
HANDICAP USERS FY 79/80

No. Days Utilized	Patient Days	Users Affected	Patient Days Cutback (14 Day Limit)
0 - 13	70,254	-	-
14	6,594	-	-
15	5,895	393	393
16	6,224	389	778
17	6,018	354	1,062
18	5,904	328	1,312
19	5,814	309	1,545
20	56,800	2,844	17,064
Total Days:	162,703		22,154

$$\% \text{ Days Cutback} = \frac{\text{Pat. Days Cutback}}{\text{Total Patient Days}} = \frac{22,154}{162,703} = 13.61\%$$

DEFENDANTS' EXHIBIT D-4(g)

Table 7

TOTAL USERS SERVED UNDER THE MEDICAID PROGRAM VIA MEDICARE (FY 79/80)

	Unduplicated Total	Users by Race			Users by Handicap	
		Black	White	Other	Blind	Disabled
Medically Needy	10342	1202	9136	4	3	1596
Categorically Needy	36709	10100	25194	1414	585	10573
Grand Total	47051	11302	34330	1419	588	12169

Note:

1. The grand total of unduplicated users shown above (47051) is comparable to the count of 42748 shown in Section J of the HCFA 2082. Since the HCFA 2082 is prepared immediately after the close of the Federal Fiscal Year (September 30), it represents approximately 11 months services rather than the full twelve months services used to develop the chart above.

DEFENDANTS' EXHIBIT D-4(h)

Table 8

INPATIENT SERVICES ANALYSIS
MEDICALLY NEEDY FY 79/80

	Unduplicated Total Users	Users by Race			Users by Handicap	
		Black	White	Other	Blind	Disabled
Total Inpatient Category of Service	17950 (1.)	2711	15207	32	10	5248
(minus) Medicaid Acute Care and Psychiatric	7608 (2.)	1509	6071	28	7	3652
(net) Recipients Served by Medicare/Medicaid jointly	10342 (3.)	1202	9136	4	3	1596

Notes:

1. Report of all paid claims for services rendered during FY 79/80 for inpatient services provided in acute care facilities for Medicaid recipients.
2. Report of Medicaid recipients receiving services in acute care facilities and reimbursed by the Medicaid Program. Includes the inpatient psychiatric program.
3. Those individuals receiving service under the Medicaid Program via reimbursement for the Medicare deductible.

DEFENDANTS' EXHIBIT D-4(i)

Table 9

INPATIENT SERVICES ANALYSIS
CATEGROICALLY NEEDY FY 79/80

	Unduplicated Total Users	Users by Race			Users by Handicap	
		Black	White	Other	Blind	Disabled
Total Inpatient Category of Service (minus) Medicaid Acute Care & Psychiatric	81720 (1.)	29048	50555	2117	922	23816
	45011 (2.)	18948	25361	702	337	13243
(net) Recipients served by Medicare/Medicaid jointly	36709 (3.)	10100	25194	1415	585	10573

Note: The notes for the previous page on the medically needy are applicable to the data on this page. (1., 2., 3.)

DEFENDANTS' EXHIBIT D-6

ANALYSIS OF IN-PATIENT UTILIZATION FOR HANDICAPPED AND NON-HANDICAPPED MEDICAID RECIPIENTS

The colums of Table 1 labeled "Number of Recipients Receiving Service" are taken from claims data provided by EDS. The impact on the handicapped of the implementation of cost containment methods which will limit the number of in-patient hospitalization days which are reimbursible to 14 cannot be accurately assessed by comparing the number of recipients served between the handicapped and the non-handicapped categories. Some allowance must be made for the fact that the number of eligible Medicaid recipients differ between the handicapped and the non-handicapped group. To clarify this, suppose there were 100 Medicaid recipients in the non-handicapped group and 100 Medicaid recipients in the handicapped group. Further, suppose that in the handicapped group the 100 recipients were eligible during the entire 12 month period, but in the non-handicapped group, the 100 recipients were eligible only during the month of January. Thus, the 100 handicapped Medicaid recipients would have access to medical service during the entire 12 month period. On the other hand, the non-handicapped Medicaid recipients would have access to in-patient medical services only one month out of the entire year. Also, assume that the handicapped and the non-handicapped utilize in-patient medical services at the same rate, and assume both the handicapped and the non-handicapped utilization rate is 1% of the population per month. Therefore, in the handicapped group you would expect 12 recipients to be hospitalized throughout the 12 months. However, in the non-handicapped group since the 100 Medicaid recipients were eligible for only one month, you would expect only one in-patient hospitalization for the non-handicapped group. Thus, if you utilized the total number of hospitalizations [DEFENDANTS' EXHIBIT

D-6(a)] to comparehandicapped and non-handicapped it would appear that the handicapped utilize at 12 times the rate as the non-handicapped. In addition, even if you normalized the number of hospitalizations by dividing by the total number of eligible recipients during the year, the handicapped would still appear to have a utilization rate that was 12 times the non-handicapped rate. Therefore, the appropriate denominator for computing in-patient utilization rates would be the number of person-years of eligibility in the non-handicapped and the handicapped categories. The number of person-years is calculated by determining the number of eligibles on a monthly basis, summing the number of eligibles in each month over 12 months and dividing by 12 to get an estimate of person-years of eligibility. In this simplified example, the number of person-years of eligibility for the non-handicapped group would be 100 x 1 ÷ 12 = 8 1/3. For the handicapped group, the number of person-years of eligibility would be 100 x 12 ÷ 12 = 100. If the number of hospitalizations in the handicapped and the non-handicapped group are compared using the person-years of eligibility as a denominator, the two rates will be identical.

The utilization rates given in Table 1 were computed by dividing the number of recipients receiving service by the number of person-years of eligibility. For example, there 3467 non-handicapped Medicaid recipients who received in-patient services of 1 day hospitalization. There were 258,656.9 person-years of eligibility for the non-handicapped group. Thus, the utilization rate for 1 day of in-patient service for the non-handicapped group is 3467 ÷ 258,656.9 x 1000 which gives a utilization rate of 13.4 persons hospitalized per 1000 person-years of eligibility. Except for 0, 1, 2 and 3 days of in-patient service, the handicapped group utilizes in-patient hospitalization services at a much higher level than the non-handicapped Medicaid recipients.

[DEFENDANTS' EXHIBIT D-6(b)] The column headed "% of Total Utilization" is computed by dividing the utilization

rates in the preceding column and by the total utilization rate for the entire category of recipients receiving service. For example, in the non-handicapped group who received 1 day of in-patient service who had a utilization rate of 13.4 persons hospitalized per 1000 person-years of eligibility accounted for 10.1% of the total of the 132.6 persons hospitalized per 1000 person-years of eligibility. When comparing the non-handicapped and the handicapped categories, Table I shows that handicapped recipients utilize in-patient services at a higher rate than non-handicapped recipients.

DEFENDANTS' EXHIBIT D-6(c)

Table 1 COMPARISONS OF MEDICAID IN-PATIENT HOSPITAL UTILIZATION RATES FOR HANDICAPPED AND NON-HANDICAPPED PERSONS DATES OF SERVICE: 7/1/79 to 6/30/80

	NONHANDICAPPED			HANDICAPPED		
Number of Days of Inpatient Service	Number of Recipients Receiving Service	Utilization Rates	% of Total Utilization	Number of Recipients Receiving Service	Utilization Rates	% of Total Utilization
0	110	.4	.3	13	.2	.1
1	3467	13.4	10.1	932	12.1	5.5
2	7614	29.4	22.2	1355	17.6	8.0
3	5787	22.4	16.9	1309	17.0	7.8
4	3472	13.4	10.1	1256	16.3	7.3
5	2643	10.2	7.7	1129	14.6	6.7
6	2100	8.1	6.1	1038	13.5	6.2
7	1598	6.2	4.7	993	12.9	5.9
8	1182	4.6	3.5	853	11.1	5.1
9	940	3.6	2.7	673	8.7	4.0
10	752	2.9	2.2	672	8.7	4.0

Number of Days of Inpatient Service	Number of Recipients Receiving Service	Utilization Rates	% of Total Utilization	Number of Recipients Receiving Service	Utilization Rates	% of Total Utilization
11	623	2.4	1.8	552	7.2	3.3
12	526	2.0	1.5	493	6.4	2.9
13	429	1.7	1.3	496	6.4	2.9
14	383	1.3	1.1	471	6.1	2.8
15	292	1.1	.8	393	5.1	2.3
16	298	1.2	.9	389	5.1	2.3
17	251	1.0	.8	354	4.6	2.1
18	206	1.8	1.4	328	4.3	2.0
19	186	.7	.5	309	4.0	1.8
20	1429	5.5	4.1	2844	37.0	16.9
TOTAL	34288	132.6		16852	219.1	

DEFENDANTS' EXHIBIT D-7

STATISTICAL OVERVIEW - TENNESSEE MEDICAID PROGRAM SERVICES
FISCAL YEAR - 1979-80

I. PROGRAM EXPENDITURES:

TOTAL -	$ 365,120,000
FEDERAL -	253,515,000
STATE -	111,605,000

II. SUMMARY OF PROGRAM ELIGIBLES[1] AND EXPENDITURES[2]:

	TOTAL -	341,960	$ 365,120,000
CATEGORICALLY	NEEDY -	307,350	$ 233,000,000
MEDICALLY	NEEDY -	34,610	$ 132,120,000

III. TOTAL NUMBER HANDICAPPED ELIGIBLES: 90,668
TOTAL HANDICAPPED EXPENDITURES: $ 136,291,504

IV. TOTAL NUMBER MEDICARE BUY-IN RECIPIENTS: 90,978
TOTAL BUY-IN EXPENDITURES[3]: $ 24,515,718

V. SUMMARY OF PROGRAM EXPENDITURES BY MAJOR COST CATEGORIES:

		EXPENDITURES
A.	INPATIENT HOSPITAL	$ 84,604,137
B.	SKILLED NURSING HOME	7,446,602
C.	INTERMEDIATE CARE	156,767,654
D.	PHARMACY	39,622,536
E.	PHYSICIAN, DENTIST, LAB, X-RAY	33,526,462
F.	OUTPATIENT	14,122,087
G.	OTHER (Home Health; EPSDT; Community Health Clinics; Family Planning)	4,979,429

1. All figures on eligibles and recipients are based on data for the month of June, 1980.
2. All figures on expenditures include both state and federal funds combined.
3. Co-insurance, deductions and premiums for medicare.

Office - Supreme Court, U.S.
FILED
MAY 18 1984
ALEXANDER L. STEVAS
CLERK

(5)

No. 83-727

IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

LAMAR ALEXANDER,
GOVERNOR OF THE STATE OF TENNESSEE, *et al.*,
Petitioners,

v.

ROSIER JENNINGS, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

---

BRIEF AMICUS CURIAE OF THE EQUAL EMPLOYMENT ADVISORY COUNCIL IN SUPPORT OF THE PETITIONERS

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

No. 83-727

LAMAR ALEXANDER,
GOVERNOR OF THE STATE OF TENNESSEE, *et al.*,
Petitioners,

v.

ROSIER JENNINGS, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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BRIEF AMICUS CURIAE OF THE EQUAL EMPLOYMENT ADVISORY COUNCIL IN SUPPORT OF THE PETITIONERS

The Equal Employment Advisory Council (EEAC), with the written consent of all parties, respectfully submits this brief as Amicus Curiae in support of the Petitioners.[1]

INTEREST OF THE AMICUS CURIAE

EEAC is a voluntary, nonprofit association organized to promote the common interest of employers and the general public in sound government policies, procedures and requirements pertaining to nondiscriminatory employment practices. Its membership comprises a broad segment of the employer community in the United States, including both individual employers and trade and in-

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[1] Their consents have been filed with the Clerk of the Court.

dustry associations. Its governing body is a Board of Directors composed primarily of experts and specialists in the field of equal employment opportunity whose combined experience gives the Council a unique depth of understanding of the practical and legal considerations relevant to the proper interpretation and application of EEO policies and requirements.

Many of EEAC's members participate in federally subsidized programs and therefore are subject to the nondiscrimination provisions of Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (herein "Section 504" or "the Act"). Accordingly, EEAC's members have a direct interest in the issue presented in this case; *i.e.*, whether a "disparate impact" or "effects" test is appropriate to determine a violation of Section 504 of the Act, or whether a showing of intentional discrimination is necessary to establish a violation.

Because of its interest in issues arising out of Section 504, EEAC has filed amicus curiae briefs with this Court in several cases construing that statute. *See, Consolidated Rail Corporation v. Darrone*, 104 S. Ct. 1248 (1984); *Southeastern Community College v. Davis*, 442 U.S. 397 (1979); and *University of Texas v. Camenisch*, 451 U.S. 390 (1981). EEAC also has filed briefs with the Court in cases involving Title VI of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000d, *et seq.*), and Title IX of the Education Amendments of 1972 (20 U.S.C. § 1988). *See, Grove City College v. Bell*, 104 S. Ct. 1211 (1984); *Guardians Association v. Civil Service Commission*, 103 S. Ct. 3221 (1983); *Cannon v. University of Chicago*, 441 U.S. 677 (1979); and *North Haven Bd. of Educ. v. Bell*, 102 S. Ct. 1912 (1982). The courts generally have recognized that the language of Section 504 and Title IX was patterned after Title VI.[2]

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[2] EEAC has participated further before the Court in cases construing the application of the adverse impact standard of liability in cases arising under Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e, *et seq.* See Int'l Bro. of Teamsters v. United

STATEMENT OF THE CASE

In this case, the Tennessee Medicaid Program determined that it no longer could afford to pay for the existing array of medicaid benefits. Because of severe budgetary constraints, the State determined it was necessary to cut back on the level of a number of existing benefits.[3] At issue here is the State's decision to reduce the number of inpatient hospital days provided by Medicaid in a fiscal year from twenty to fourteen days. Respondents brought suit seeking to enjoin the proposed reduction. One of the theories of liability was that the proposed changes would violate Section 504 of the Rehabilitation Act.

Respondents primary argument is that Section 504 of the Act proscribes conduct that has an adverse impact (or effect) on the handicapped and that the decrease in hospital days would have an impermissible effect on handicapped Medicaid recipients. The district court below, however, held that the Respondents failed to establish that the limitation of fourteen days would in fact have a discriminatory impact upon handicapped Medicaid recipients. See *Jennings v. Alexander*, 518 F. Supp. 877, 881 (N.D. Tenn. 1981).[4] Moreover, the district court

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States, 431 U.S. 324 (1977); Connecticut v. Teal, 457 U.S. 440 (1982). Finally, EEAC filed a brief as amicus curiae in General Building Contractors v. Pennsylvania, 458 U.S. 375 (1982), a case holding that a showing of an intentional violation is necessary to establish a violation of 42 U.S.C. § 1981.

[3] The budgetary reasons for the cutback are explained more fully in the brief of the State of Tennessee.

[4] The amicus, EEAC, concurs with the State that the statistical evidence presented below by the Respondents does not establish that the proposed cuts would have an adverse impact upon handicapped recipients. Our primary focus, however, is on the broader question of whether the adverse impact theory is applicable to Section 504 of the Act. We rely, therefore, on the State to argue that the Respondents' statistical evidence does not show that these particular cutbacks would have an adverse impact.

found that even if the evidence could be construed to demonstrate a disparate impact upon the handicapped as a separate group, the impact was not the type that Section 504 was intended to proscribe. *Id.* The court stated that "[b]oth handicapped and nonhandicapped Medicaid recipients will have identical services available for their use, subject to the same durational limitation." 518 F. Supp. 883. In the district court's view, while Section 504 may require the State to give handicapped individuals equal access to Medicaid benefits, neither the section nor the applicable regulations mandate equal results for the handicapped and nonhandicapped. 518 F. Supp. at 883, 884.[6] And as the court further noted, "the same durational limit works without regard to any particular handicapping condition and regardless of the particular cause of hospitalization." 518 F. Supp. at 885.

Because the coverage would be terminated whether or not the recipient was handicapped, the court could find no discrimination by reason of handicap. Thus, in the district court's view, "so long as a service is offered in equal quality, scope and duration to both handicapped and nonhandicapped recipients, and handicapped recipients are actually afforded equal access to that service, the mandates of § 504 have been satisfied." *Id.* at 886.

The Sixth Circuit, in a 2-1 decision, reversed the decision of the district court. Thus, with little discussion, the appellate court stated that the effects test is a suffi-

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[6] The district court's decision, having found no adverse impact covered by Section 504, did not discuss at any length the underlying issue of whether an adverse impact claim is cognizable under the Act. The court stated merely:

> While agreeing that a disparate impact test is the appropriate standard to apply in a § 504 case, the court holds that the adverse impact arguably shown in this case does not amount to discrimination under § 504.

518 F. Supp. at 885.

cient basis upon which to base a violation of Section 504. *Jennings v. Alexander*, 715 F.2d 1036, 1041-42 (6th Cir. 1983), *pet. for cert. granted*, 52 U.S.L.W. 3596 (February 21, 1984). It then concluded that the statistical studies introduced before the district court indicated that the handicapped population of Medicaid recipients would suffer proportionally more from the reduction in hospital benefits than the nonhandicapped recipients. *Id.*, 715 F.2d at 1042 & n.7.

The Sixth Circuit stated that the Medicaid program was intended to provide more than equal access to the program. Rather, the court felt that the objective of the Medicaid program was "to afford the best cure, therapy, or preventive treatment that the allotted funds can provide." 715 F.2d at 1043 n.8. Thus, although the Sixth Circuit held that "[t]he state clearly proved that it was justified in attempting to reduce its Medicaid expenses" (715 F.2d at 1043), it felt that the State's rationale was not sufficiently supported by the evidence. *Id.* at 1044. The case was remanded to the district court to give the State a chance to justify its reduction of hospital days as compared with the plaintiff's alternative, which would have limited the number of days of hospital coverage on a per stay basis.

Judge Merritt dissented from the majority panel decision. Agreeing with the district court, he argued that the "equal access" test was the only workable rule to apply to Section 504. In his view, the adverse impact standard would mean that any reduction of spending would have a disparate effect on some class of patients, thereby creating "a whole new source of challenges to state budgetary decisions." 715 F.2d at 1047. Thus, application of the adverse impact standard would mean that some class of plaintiffs would always succeed in its challenge to a budget reduction.[6] Judge Merritt stated

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[6] The dissent noted, for example, that the plaintiff's alternative solution that would limit the number of trips to the hospital would

that he did not believe that Congress intended Section 504 to authorize the federal courts to step in and control the state's budgetary process. The dissent argued, moreover, that inasmuch as the majority opinion would require a "form of affirmative action or equality of results," it was at odds with the Supreme Court's decision in *Southeastern Community College v. Davis*, 442 U.S. 397 (1979). There, the Court held that Section 504 does not compel federal funds recipients to undertake affirmative action favoring the handicapped.

SUMMARY OF ARGUMENT

Adoption of the adverse impact standard would be at odds with the statutory language and purpose of Section 504 of the Rehabilitation Act. Section 504 establishes its own criteria for determining whether or not its provisions have been violated. It prohibits a federal funds recipient from excluding or discriminating against an "otherwise qualified handicapped individual" "solely by reason of his handicap." Thus, the statutory language puts in issue the qualifications of the handicapped individual and the motive or intent of the recipient of federal funds. By contrast, the adverse impact standard, developed under Title VII in *Griggs v. Duke Power Co.*, 401 U.S. 424 (1971), does not require a showing of an intent to discriminate or an evaluation of the qualifications of individual members of protected groups.

Moreover, there are substantial differences between discrimination on the basis of race or sex (the groups protected by Titles VI, VII and IX) and discrimination against the handicapped. Unlike race or sex, a physical

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fall hardest on the class of patients who must come often to the hospital for short stays. Thus, in his view, there appeared to be "no way under the majority's opinion that a state can modify its medical program without some disparate impact on some class of patients—unless the state simply abolished Medicare altogether, a solution that would presumably be equal only because it denies relief to everyone." 715 F.2d at 1049-50.

or mental handicap may affect one's ability to function and, in appropriate circumstances, may provide legitimate grounds for exclusion of the handicapped individuals. *Southeastern Comm. College v. Davis*, 442 U.S. 397 (1979). To be realistic, Congress recognized that the existence of a handicap often defines the extent to which a disabled person may participate in particular employment opportunities. For these reasons, Congress drafted Section 504 to require an analysis of a specific individuals' qualifications. It did not allow a violation to be premised on the basis of group effects.

Because of the imprecise and complex nature of handicap discrimination, the adverse impact model would be inappropriate. The decision below presents the real danger that its logic could be extended to find discrimination merely because of the absence of individuals with a specific handicap in an organization's workforce. Unlike race and sex, the definition of handicap is not susceptible to precise categorization. There is no readily identifiable and homogeneous class of handicapped persons, and there likewise is no fixed reference class with which treatment of the handicapped could be compared. Given the difficulties in matching the qualifications of broad groups of handicapped persons with the requirements of different jobs, it would be impossible to deal with handicap discrimination issues on any basis except the qualifications of individuals for particular jobs.

In addition, the adverse impact approach requires adequate statistical information about the qualifications of the minority and female workforce in the relevant labor market, which then is compared to the racial or sexual makeup of a particular employer's workforce. There is no adequate available source of workforce information about the availability of qualified handicapped persons. Also, because the number of handicapped persons with a particular handicap would be so small in relation to the overall workforce, such statistics as could be mustered would have little legal significance or predictive value.

As long as qualified handicapped individuals are given the same opportunities as persons who are not handicapped, there can be no violation of Section 504. Section 504 does not require a preference for handicapped individuals beyond equal access and it would be improper for the courts to read Section 504 in the broader manner of the Sixth Circuit below. *Southeastern Comm. College v. Davis, supra.*[7]

ARGUMENT

I. SECTION 504'S BAN ON DISCRIMINATION AGAINST QUALIFIED INDIVIDUALS SOLELY ON THE BASIS OF HANDICAP CANNOT BE CONSTRUED TO ENCOMPASS THE ADVERSE IMPACT THEORY OF DISCRIMINATION.

A. Section 504's Language Excludes Enforcement by Use of the Adverse Impact Theory.

Section 504 establishes its own criteria for determining whether or not its provisions have been violated. An examination of the statute's language indicates that the focus is on the individual handicapped person, rather than on the impact on groups of the handicapped. Section 504 provides in pertinent part that:

> No *otherwise qualified* handicapped *individual* in the United States, as defined in section 706(6) of this title, shall *solely by reason of his handicap*, be excluded from the participation in, be deneid the

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[7] There are other related reasons why the adverse impact model should not be applied generally to Section 504, particularly in the private employment sector. Unlike the instant case where the parties agreed that the definition "handicapped individual" would be equated with Medicaid recipients who were blind or disabled (715 F.2d at 1039 n.2), many Section 504 cases involve a dispute over whether a particular individual is indeed handicapped. Moreover, often it would not be readily apparent that the employer's employment practices could be shown to cause an adverse impact on the handicapped. As detailed more fully below, the definitional difficulties in determining handicapped issues are unsuited for the adverse impact model.

> benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. . .

29 U.S.C. § 794 (emphasis added).

Accordingly, as the first analytical step, the individual must show that he was *qualified* to perform his job *in spite of* his handicap. *Southeastern Community College v. Davis*, 442 U.S. 397 (1979). Thus:

> [I]n the more typical suit under § 504, the defendant acknowledges reliance on the plaintiff's handicap and since the plaintiff's handicap may be a permissible factor to be taken into account in determining whether he is qualified, the order of presentation of proof in such cases cannot be framed in terms of permissible versus impermissible factors. The pivotal issue is not whether the handicap was considered but whether under all of the circumstances it provides a reasonable basis for finding the plaintiff not to be qualified or not as well qualified as other applicants.

Doe v. New York University, 666 F.2d 761, 777 (2d Cir. 1981). *See also Pushkin v. Regents of the Univ. of Colorado*, 658 F.2d 1372, 1385 (10th Cir. 1981). Accordingly, under Section 504, a "case by case analysis of the appropriate burden of proof is required due to the varying factual situations presented in each individual case." *Norcross v. Sneed*, 33 FEP Cases 679, 686 (W.D. Ark. 1983).

As a second step in Section 504 cases, the individual plaintiff must show that his discriminatory treatment was "solely by reason of his handicap." This emphasis on the institution's motivation requires a showing that the employer or institution *intentionally* discriminated on the basis of the handicapped condition. As now shown, both steps foreclose the use of the disparate impact theory of discrimination developed under Title VII of the Civil Rights Act of 1964.

Unlike Section 504, under the adverse impact theory it is not necessary to prove that the employer discriminated against an individual "because of" his race, sex, national origin or religion. Rather, the adverse or disparate impact method of proof under Title VII is used to attack employment selection criteria that are facially neutral or "fair in form," yet fall more harshly on a protected class of employees. *Int'l Bro. of Teamsters v. United States*, 431 U.S. 324, 335 n.15 (1977). In order to establish a prima facie case of disparate impact, a plaintiff must show that a particular facially neutral employment practice produces a significant adverse impact on a protected group of employees. The employer's intent to discriminate against a class of employees is not at issue. *Griggs v. Duke Power Co.*, 401 U.S. 424, 432 (1971). In further contrast to Section 504, which relates specifically to the qualifications of the individual, under the adverse impact theory "[t]here is no requirement . . . that a statistical showing of adverse impact must always be based on analysis of the characteristics of actual applicants." *Dothard v. Rawlinson*, 433 U.S. 321, 330 (1977).

Thus, the analysis required to find a violation of Section 504 differs from the disparate impact approach in three crucial ways. First, Section 504 by its terms does not apply to neutral practices but instead addresses practices that discriminate "solely on the basis of" handicap. Second, Section 504 requires an inquiry into the qualifications of individual persons—a requirement that is not necessary under the disparate impact theory to establish a prima facie case. Third, Section 504 requires a showing of a discriminatory motive, i.e., discrimination "by reason of . . . handicap" (29 U.S.C. § 794)—a requirement absent from the adverse impact theory.

Accordingly, Section 504 is more analogous to the disparate treatment theory of Title VII. Under the disparate treatment theory of discrimination, the plaintiff

must demonstrate a discriminatory motive or intent on the part of the employer. *See, e.g., Int'l Bro. of Teamsters v. United States*, 431 U.S. at 335-36, which held that a disparate treatment case under Title VII is based upon a showing that a person is treated less favorably "*because of* such individual's race, color, religion, sex, or national origin." Like the words "by reason of" in Section 504, the words "because of" indicate that "proof of discriminatory *motive* is crucial." 431 U.S. at 335-36 n.15 (emphasis added).

As this Court has stated, the disparate treatment approach requires the following showing to demonstrate a prima facie case of intentional discrimination:

> (i) that [the individual] belongs to a racial minority; (ii) that he applied and was qualified for a job for which the employer was seeking applicants; (iii) despite his qualifications, he was rejected; and (iv) that, after his rejection the position remained open and the employer continued to seek applicants from persons of complainant's qualifications.

McDonnell Douglas Corp. v. Green, 411 U.S. 792, 802 (1973). Section 504's requirements are closely analogous because they stress the individual's qualifications and the motive for the institution's actions. Indeed, Section 504 is more demanding than the traditional disparate treatment standard because it permits the employer to consider the individual's handicap in determining whether the individual is qualified. *See Southeastern Comm. College v. Davis*, 442 U.S. 397 (1979).

Thus, application of Section 504's handicap discrimination provision requires a recognition of its unique requirements not present in other statutory schemes. The courts which have closely examined Section 504 have recognized these special factors. As stated by the Second Circuit:

> A § 504 action frequently does not lend itself easily to the analysis used for allocation of burdens and order of proof used in suits alleging discrimination

> on impermissible factors (race, color, religion, sex or national origin) in violation of Title VII. . . .

Doe v. New York University, 666 F.2d at 776. In addition:

> The Title VI and Title IX models were not automatically adaptable to the problem of discrimination against the handicapped, but involved a very different analytical undertaking. Indeed, attempting to fit the problem of discrimination against the handicapped into the model remedy for race discrimination is akin to fitting a square peg into a round hole. . . .

Garrity v. Gallen, 522 F. Supp. 171, 206 (D.N.H. 1981). For all these reasons, it is clear from the language of Section 504 that the adverse impact approach would be inappropriate as a burden of proof scheme.[8]

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[8] Although Section 504 has been described as "the first Federal Civil rights law protecting the rights of handicapped persons" (42 Fed. Reg. 22,676 (1977) (remarks of then HEW Secretary Joseph Califano), it would be incorrect to assume that there is an exact correlation between the concept of handicap discrimination and discrimination on the basis of race, national origin or sex. As has been argued:

> This comparison is accurate in one sense, yet misleading in another. To the extent that discrimination on the basis of handicap, race, and national origin may often result from misconceptions and stereotypes, it is accurate to compare handicap to race and national origin. Such a comparison is misleading, however, because it serves to obscure a very important distinction. Unlike race or national origin, a physical or mental handicap may affect one's ability to function and may sometimes constitute legitimate grounds for exclusion. Distinctions drawn on the basis of handicap, as opposed to those drawn on the basis of race or national origin, do not always reflect stereotyped attitudes about disadvantaged individuals since, realistically speaking, a handicap has practical limitations that define the extent to which a disabled individual may participate in normal societal activities.

Cohen, *Discrimination on the Basis of Handicap: The Status of Section 504 of the Rehabilitation Act of 1973*, 65 Iowa L. Rev. 446, 453 (1980).

B. Rejection of an Effects Test Would Not Be Inconsistent With This Court's Title VI *Guardians* Decision.

Insofar as Section 504 may be affected by decisions under Title VI of the Civil Rights Act of 1964, it is clear that Title VI would not require an application of the effects test in the instant case. The Court has noted previously that Section 504 was patterned after Title VI of the Civil Rights Act of 1964. *See Community Television of Southern California v. Gottfried*, 103 S. Ct. 885, 892 (1983); and *Consolidated Rail Corporation v. Darrone*, 104 S. Ct. 1248, 1250 (1984). Moreover, in 1978, the Rehabilitation Act was amended to add a new Section 505 (29 U.S.C. § 794(a)(a)(2)) which applies to Section 504 the remedies, procedures and rights available under Title VI. This Court recently reviewed the standard required to prove a violation of Title VI. Seven members of the Court "agree[d] that a violation of the statute itself requires proof of discriminatory intent." *Guardians Ass'n v. Civil Service Commission of the City of New York*, 103 S. Ct. 3221, 3235 n.1 (1983) (opinion of Justice Powell).

In *Guardians*, Justices Brennan, Marshall, Blackmun and Stevens, however, would hold that proof of discriminatory effect suffices to establish liability "only when the suit is brought to enforce the regulations rather than the statute itself." 103 S. Ct. at 3235 n.1 (opinion of Justice Powell). That view may be limited to Title VI and should not be applied to the Section 504 regulations in this case. The regulations make clear that Section 504 is to be construed as requiring merely equal access to benefits and services available to handicapped individuals. 84 C.F.R. § 84.4(b)(2) provides that:

> (2) For purposes of this part, aids, benefits, and services, to be equally effective, are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons, but

> must afford handicapped persons *equal opportunity* to obtain the same result, to gain the same benefit, or to reach the same level of achievement in the most integrated setting appropriate to the person's needs. (Emphasis added)

See also Southeastern Community College v. Davis, 442 U.S. at 410 (Section 504 merely requires equal treatment, not affirmative action). And as the dissent and district court pointed out below, where equal treatment has been afforded the handicapped, it could not reasonably be argued that such practices "have the *effect* of subjecting qualified handicapped persons to discrimination on the basis of handicap." See 84 C.F.R. § 84.4(b)(4) (emphasis added).

Indeed, if these regulations were construed as adopting an effects test, they would be inconsistent with 84 C.F.R. § 84.4(b)(2) and with the specific language of Section 504 and hence unenforceable. *See University of Texas v. Camenisch*, 451 U.S. 390, 399 (1981) (opinion of Chief Justice Burger) ("The Secretary has no authority to rewrite the statutory scheme by means of regulations."); and *Garrity v. Gallen*, 522 F. Supp. 171, 208 (D.N.H. 1981).

Finally, this Court is not required to defer to any administrative interpretation of Section 504 that adopts an effects test. The history of Section 504's regulations contrasts sharply with the Title VI regulations, which were contemporaneous with the enactment of Title VI and were consistently applied. See 103 S. Ct. at 3240 (opinion of Justice Marshall). As this Court previously noted, the Department's reluctant and inconsistent history with respect to Section 504's regulations "substantially diminishes the deference to be given to [HHS's] present interpretation of the statute." *Southeastern Community College v. Davis*, 442 U.S. at 412-13 n. 11. For all these reasons, it is evident that rejection of an effects test in this case would be consistent with the language of

Section 504 and with this Court's previous interpretations of Title VI.[9]

II. BECAUSE OF THE IMPRECISE AND COMPLEX NATURE OF THE CONCEPT OF "HANDICAP DISCRIMINATION," THE ADVERSE IMPACT MODEL OF ANALYSIS WOULD NOT BE APPROPRIATE.

Although Congress chose to use the term "discrimination" in both Section 504 and Title VII, Congress showed its caution by limiting the application of Section 504 to "otherwise qualified handicapped individuals" who face disparate treatment "solely" on the basis of handicap. There are sound reasons for this distinction.

Handicaps are not susceptible to precise categorization because they are not the same in kind and do not necessarily have the same effect on employment opportunity as do the types of discrimination prohibited by Title VII. Title VII is premised, in part, on the concept that no inherent differences exist between the general public and persons protected on the basis of race, color, religion, sex, or national origin. The courts have recognized this difference between the handicap discrimination statutes and other nondiscrimination statutes.

> First, unlike classifications based on race, there are no readily apparent divisions among the handicapped. Rather, mental and physical handicaps cover a continuum, from color-blindness or forgetfulness on the one hand to total spasticity or profound mental retardation on the other. In relation to other human beings, we are all handicapped to a certain degree, however insignificant or debilitating that handicap may be.
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> * * * *

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[9] Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 *et seq.*) also was patterned after Title VI. It has been held that a violation of Title IX requires an intentional discriminatory act and disparate impact alone is not sufficient to establish a violation. See Cannon v. The University of Chicago, 648 F.2d 1104 (7th Cir. 1981), *cert. denied*, 454 U.S. 1128 (1981).

> Assessing the capability of various individuals to perform without knowledge of the particular task under consideration and its various requirements, or without an individualized determination of their strengths and weaknesses would appear to be impossible. In fact, it was partly in recognition of this fact that Congress passed § 504—to encourage treatment of the handicapped on the basis of individualized assessment of ability. . . .

Garrity v. Gallen, 522 F. Supp. at 206.

Handicaps differ widely in kind and degree and there is no readily identifiable and homogeneous class of handicapped persons. The Rehabilitation Act's definition of handicapped is so broad that discrimination can only be defined in terms of disparate treatment of differently and uniquely handicapped individuals.[10] Thus, there is no fixed reference class with which treatment of the handicapped can be compared because each handicapped person must be treated differently in order to be afforded equal access to employment. Indeed, identical treatment may, in fact, constitute discrimination. For example,

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[10] Applicable Department of Health and Human Services regulations define "handicapped persons" as follows:

> "Handicapped persons" means any person who (i) has a physical or mental impairment which substantially limits one or more major life activities, (ii) has a record of such an impairment or (iii) is regarded as having such an impairment.
>
> (2) As used in paragraph (j)(1) of this section, the phrase:
>
> (1) "Physical or mental impairment" means (A) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovasular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

45 C.F.R. § 84.3(j).

epileptics may be properly excluded from some jobs but not others. The nature and the degree of epilepsy may affect whether epileptics are qualified for various jobs. It, therefore, would be difficult to classify all epileptics as a member of a common class with typical claims.[11] As stated by the Tenth Circuit in an analogous context in a case interpreting 42 U.S.C. § 1985(3):

> It is apparent that different individuals are handicapped in vastly different ways, for different periods of time, and to very different degrees or extent. The variations in each category are infinite and as a consequence the term "handicapped" does not have a definition capable of a reasonably precise application for the purposes before us [i.e., defining a class of handicapped persons].

Wilhelm v. Continental Title Co., 720 F.2d 1173, 1176 (10th Cir. 1983), *cert. denied*, 52 U.S.L.W. 3687 (1984).

Similarly, unlike race, color, national origin, or sex discrimination—which are addressed in Title VI, Title

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[11] As one commentator has noted, administrative enforcement of handicap discrimination laws is much more difficult than enforcement of laws prohibiting discrimination against females or minorities:

> In contrast, review of an employer's treatment of epileptics, for example, will not provide the same insights about how to treat other handicapped persons or, indeed other epileptics. Nor will EEOC or any other enforcing agency be able to offer guidance with the specificity it has provided in administration of Title VII in its present form. The task would require a staff with medical expertise concerning each type of impairment which gives rise to disability, and vocational expertise concerning the significance of the impairments upon the whole range of employment opportunities.

Peck, *Employment Problems of the Handicapped: Would Title VII Remedies be Appropriate and Effective?*, 16 U. Mich. J.L. Ref. 343, 370 (1983). The author concluded: "Even the disparate impact test developed under Title VII may not be well suited for dealing with the range of problems that will be encountered in providing and expanding job opportunities for the handicapped." *Id.*, at 346.

VII and Title IX—"handicapped discrimination" is not susceptible to precise categorization. It is different in kind and does not necessarily have the same effect on equal opportunity as with other forms of discrimination. Former HEW Secretary Matthews explained the unique definitional problems in a letter accompanying the publication of the initial proposed Section 504 regulations of HEW:

> Section 504, however, differs conceptually from both title VI of the Civil Rights Act of 1964 and IX of the Education Amendments of 1972. The premise of both title VI and IX is that there are no inherent differences or inequalities between the general public and the persons protected by these statutes and, therefore, there should be no differential treatment in the administration of Federal programs. The concept of section 504, on the other hand, is far more complex. Handicapped persons may require different treatment in order to be afforded equal access to federally assisted programs and activities, and identical treatment may, in fact, constitute discrimination. The problem of establishing general rules as to when different treatment is prohibited or required is compounded by the diversity of existing handicaps and the differing degree to which particular persons may be affected. Thus, under section 504 questions arise as to when different treatment of handicapped persons should be considered improper and when it should be required.

41 Fed. Reg. at 20296 (1976).[12]

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[12] Similar concerns were expressed by Joseph A. Califano, Jr., then Secretary of Health, Education and Welfare, in his background explanation to the 1977 HEW regulations on Section 504. Secretary Califano explained:

> From the outset, the Department has recognized that the problem of ending discrimination on the basis of handicap presents considerations that are extremely complex. The diversity of types of handicaps, as well as the wide variety of settings in which programs financed by the Department are offered,

The difficulties in applying Title VII standards and concepts of discrimination were also recognized by the United States Commission on Civil Rights (herein "the Commission"). The Commission has cautioned:

> [B]ecause the classification "handicap" differs from other antidiscrimination classifications, such as race, sex, national origin, age and religion, there are significant limits to applying established civil rights law to discrimination based on handicap. . . . [T]his chapter counsels against mechanically incorporating in handicap discrimination law the antidiscrimination concepts and standards developed in other civil rights contexts.[18]

The Commission went on to discuss the differences between the groups protected by Section 504 and Title VII:

> All too often, racial and ethnic minorities, women, religious minorities, and elderly people are stereotyped, although each group is comprised of diverse and unique individuals. Nonetheless, the members of each group share one characteristic—race, national origin, being female, age, or membership in a religion. Because the handicap category lumps together all those who do not fit into the "normal" category, membership does not require even a single common characteristic. It is the difference from any of the vast number of physical and mental characteristics considered normal that defines membership in the

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make the task of prescribing general rules of nondiscriminatory treatment a difficult one.

42 Fed. Reg. 22677, May 4, 1977.

[18] United States Commission on Civil Rights, *Accommodating the Spectrum of Individual Abilities*, Clearinghouse Publication 81, September 1983 at p. 142 (herein "Civil Rights Commission Study"). Although the Commission views the HHS Section 504 regulations as establishing an effects test (Study at 5, 52, 122, 130), it also noted the disagreement and inconsistencies in court decisions relating to that issue (*Id.*, at 150).

> handicap class. As a result, handicapped people are an exceedingly heterogenous group.[14]
>
> • • • •
>
> Because race, sex, and national origin have no direct connection with functional abilities, this neutrality doctrine [of Title VII] prohibits consideration of these characteristics except in the remedial context of affirmative action.
>
> The handicap classification, in contrast, encompasses real functional limitations. The goal of handicap antidiscrimination law, therefore, cannot be complete neutrality or indifference to the defining characteristic.[15]

It thus is apparent that the substantial differences between traditional protected groups and the handicapped make it inappropriate to apply the concept of adverse impact discrimination to suits brought under Section 504 of the Act.

III. THE INSUFFICIENT AND IMPRECISE NATURE OF AVAILABLE STATISTICAL DATA RELATING TO THE HANDICAPPED MAKES THE USE OF A *GRIGGS*-TYPE ADVERSE IMPACT ANALYSIS INAPPROPRIATE IN CASES ARISING UNDER SECTION 504.

Even under Title VII, in which the adverse impact approach has been adopted, the courts have emphasized that not all statistics are probative of discrimination. In *Teamsters*, the Supreme Court cautioned that "statistics are not irrefutable; they come in infinite variety and like any other kind of evidence they can be rebutted. In short, their usefulness depends on all the surrounding facts and circumstances." 431 U.S. at 340. In *Hazelwood School District v. United States*, 433 U.S. 299 (1977), the Court developed the proper form of statistical analy-

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[14] Civil Rights Commission Study at 145-46.

[15] Civil Rights Commission Study at 153.

sis in Title VII cases. The usefulness of statistics, it said, depends upon the identification of the appropriate comparative data base, *i.e.*, the relevant labor market to which the employer's workforce is to be compared.

Hazelwood makes clear that, at a minimum, for statistics to be probative there needs to be a comparison between the composition of the relevant components of the employer workforce and the composition of those persons available in the relevant labor market with the skills to perform the employer's jobs. Unless workforce statistics and the qualified labor pool are tailored to each other and appropriately refined, no inference of discrimination is reasonable or permissible, because any resulting disparity may be caused by numerous factors other than discrimination. The Supreme Court has observed, in this regard, that broad-based statistics which include a substantial number of people who realistically cannot be considered potential applicants are "virtually irrelevant" for comparison purposes. *New York City Transit Authority v. Beazer*, 440 U.S. 568, 586 (1979); *Hazelwood*, 443 U.S. at 308 n.13; *Int'l Bro. of Teamsters*, 431 U.S. at 340-41 n.20. Accordingly, if the available statistics reveal little about the class of "otherwise qualified" handicapped individuals, they may not be relied upon to demonstrate the presence of discrimination. *New York City Transit Authority v. Beazer*, 440 U.S. at 585 & n.29 ("[E]vidence showing that the figures for the general population might not accurately reflect the pool of qualified job applicants undermines the significance of such figures.") As now shown, these principles make inappropriate the use of adverse impact theory in handicap discrimination cases.

In contrast to the typical employment discrimination case based upon race or sex where a comparative analysis between the percentage of minorities or women in the employer's work force and the qualified outside relevant labor market might be probative of discrimination, there

simply is no way to obtain sufficient statistical information upon which to base a prima facie case of adverse impact discrimination against the handicapped.[16]

The first problem is that there is no adequate source or sources of statistical information on the availability of qualified handicapped persons. As the United States Commission on Civil Rights has concluded:

> There is no single repository of adequate national data on the handicapped population. Instead, demographic information must be culled from four distinct sources: service eligibility statistics, service delivery statistics, population surveys, and ad hoc studies. Each of these types of data has deficiencies. Service eligibility and delivery statistics are limited to those people who seek specific services from certain agencies; the data collection lacks breadth and standardization, and the records are often duplicative or incomplete. Existing population surveys have a variety of problems. Some ask general questions on activity restrictions but yield no accurate or detailed disability information. Others are rich in diagnostic information but tend to exaggerate the rate of disability or fail to provide adequate information about functional limitations or activity restrictions. Other surveys report major restrictions but do not indicate their causes. Ad hoc studies tend to be sharply focused examinations of local or State conditions. Because these limited studies are not designed to

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[16] In the instant case, there appears to be common agreement between the parties that handicapped individuals include only blind and disabled persons. There also seems to be agreement as to the portion of eligible Medicaid recipients who were to be considered handicapped. This situation is atypical of the usual Section 504 case in which the statistical evidence would be disputed as to the availability and qualifications of handicapped individuals. As has been observed, "it may be extremely difficult to produce any useful comparative data regarding the potential applicant pool [of handicapped individuals] either within the local area or the Standard Metropolitan Statistical Area (SMSA)." Gittler, *Fair Employment and the Handicapped: A Legal Perspective*, 27 DePaul L. Rev. 953, 972 (1978) (herein "Gittler").

> take national samples, it is not possible to extrapolate from them to the national population.
>
> The available statistics are difficult to aggregate because of inconsistent methodologies and definitions used by the different sources of data.

Civil Rights Commission Study at 10-11 (footnotes omitted).[17]

The Civil Rights Commission pointed out the differences between the use of statistics in traditional civil rights cases (such as race discrimination) and in handicap discrimination cases:

> To date, statistics have been used infrequently with respect to handicap discrimination. Few court decisions have viewed statistical evidence as proving disparate impact or suggesting intentional discrimination. It would seem the absence of handicapped participants in a program or activity with many nonhandicapped participants might be evidence of discrimination. The total absence of people commonly considered handicapped from a large employer's workforce, for example, is statistically so unlikely as to suggest discrimination. *Given the connection between handicaps and functional limitations, however, disproportionate underrepresentation of people with a particular type of handicap does not necessarily indicate unlawful discrimination.*

Civil Rights Commission Study at 157 (emphasis added).[18]

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[17] The Civil Rights Commission also pointed out that the different usages of the terms "handicap" and "disability" in the Social Security Act (42 U.S.C. § 423(d)) and the Rehabilitation Act "hamper any correlation of the statistics generated by the various programs, since the samples are divergent by definition." Civil Rights Commission Study at 11 n.42. The Commission also noted that there are "major differences in the methodologies used to collect data" by federal agencies that collect such data—the Social Security Administration, the National Center for Health Statistics and the Bureau of Census. Civil Rights Commission Study at 11.

[18] As pointed out in Prewitt v. United States Postal Service, 662 F.2d 292, 307 (5th Cir. 1981):

In addition, it has been argued that "meaningful statistics cannot be obtained for the handicapped because of the virtual absence of handicapped persons in the labor market relative to the number of persons employed." Gittler, 27 DePaul L. Rev. at 971. Because of this small proportion of the handicapped in the working population,

> the data will always show that few if any handicapped are currently employed by the defendant employer compared to the number of handicapped persons in the overall population. The obvious effect is that any statistics introduced in support of a handicapped individual's charge would not be significantly probative of the issue of discrimination. Otherwise, if the statistics were given the same weight for handicapped persons as they are for blacks or women, the handicapped plaintiff would always prevail.

Id., at 972.[19] Gittler also points out that "even if disparities could be shown between the employment statistics of the employer and the relevant labor market pool,

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> One difference . . . is that, when assessing the disparate impact of a facially-neutral criterion, courts must be careful not to group all handicapped persons into one class, or even into broad subclasses. This is because "the fact that an employer employs fifteen epileptics is not necessarily probative of whether he or she has discriminated against a blind person.

Thus, it has been concluded that:

> it is apparent that definitional problems will complicate enforcement of a statutory prohibition of discrimination against the handicapped to a far greater degree than they have with enforcement of a prohibition of discrimination on the basis of race, sex, or national origins.

Peck, 16 U. Mich. J.L. Ref. at 357

[19] A similar deficiency in the adverse effects test was pointed out by the dissent below. Judge Merritt observed that "the disparate impact test will always work for some class of illness; it will always produce a finding of discrimination." Jennings v. Alexander, 715 F.2d at 1049.

such statistical analyses would be so small as to have little legal significance or predictive value." *Id.*, at 973.[20]

For all these reasons, it is apparent that there is not an adequate statistical basis upon which to apply the adverse impact approach to the general run of Rehabilitation Act cases. Thus, Congress had good reasons for limiting the protections of the Rehabilitation Act to the individual who could demonstrate that he was qualified for a particular job in spite of his particular form of handicap.

IV. THE SIXTH CIRCUIT IMPROPERLY OVERRODE THE LEGITIMATE BUDGETARY DECISION OF THE STATE GOVERNMENT BECAUSE BY PROVIDING EQUAL ACCESS TO HOSPITAL BENEFITS, THE STATE HAS COMPLIED WITH THE REQUIREMENTS OF SECTION 504

EEAC's final concern is that the lower court's decision would permit the courts to second-guess the legitimate budget decisions of governments who must administer the Medicaid program in the face of dwindling revenues. As argued by the dissent below:

> Without a clear, bright-line distinction based on access, like the District Court makes, the Court's decision will create a whole new source of challenges to state budgetary decisions. People with physical ail-

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[20] *See also* Lang, *Protecting the Handicapped from Employment Discrimination: The Job-Relatedness and Bona Fide Occupational Qualification Doctrines*, 27 DePaul L. Rev. 989, 1001, 1008 (1978), which noted with respect to an analysis of employee selection criteria that "in many instances the criterion-related validity study favored by the EEOC Guidelines will be impractical, if not impossible to apply to the handicap context due to a lack of a significant number of handicapped test takers in the sample." This conclusion would also apply to the HHS regulations at issue here. See 45 C.F.R. § 84.13. Lang also concluded that the traditional Title VII method of statistical proof might not be readily transferable to handicap cases because "the number of handicapped applicants may not be a large enough base for a traditional statistical study." *Id.*, at 1007.

> ments depend on a myriad of state services more heavily than do people with no ailments. When a local government decides to reduce the quality, frequency or financing for some service, for example, bus service, some group could make a case of discrimination, for example, by showing that they use the buses more than others. Across-the-board cuts in welfare, social security, education and many other benefits will affect some groups more than others and will open the way to litigation. I do not believe that Congress intended this statute to authorize the federal courts to step in and control the state budgetary process when cuts in appropriations affect asthmatics, or some other class of patients, somewhat more heavily than another group of patients. 715 F.2d at 1047.

The decision below goes far beyond any other in permitting the courts to set aside the legitimate budgetary decisions of state governments. Thus, the decision would lay the groundwork for an interpretation of nondiscrimination statutes that is too openended. As stated by the Second Circuit in an analogous context:

> If, for example, a court were to assess alternative ways of saving funds throughout the administration of a city or even throughout the administration of the health care function, it would seriously risk substituting its own judgment for that of the city's elected officials and appointed specialists. We are skeptical of the capacity and appropriateness of courts to conduct such broad inquiries concerning alternative ways to carry out municipal functions. Once a court is drawn into such a complex inquiry, it will inevitably be assessing the wisdom of competing political and economic alternatives. Moreover, such policy choices would be made without broad public participation and without sufficient assurance that the alternative selected will ultimately provide more of a benefit to the minority population.

Bryan v. Koch, 627 F.2d 612, 619 (2d Cir. 1980) (Title VI did not prevent the closing of a hospital for budgetary reasons).

This court's recent decisions have stressed repeatedly that judicial scrutiny of state budget decisions should give great leeway to the decisions of local administrators. For example, *Board of Education v. Rowley*, 102 S. Ct. 3034, 3043 (1981), held that the Education for all Handicapped Children Act (20 U.S.C. § 1041 *et seq.*) was not intended to "guarantee any particular level of education" or "produce any particular outcome."[21] The Court cautioned that "courts lack the 'specialized knowledge and experience' necessary to resolve 'persistent and difficult questions of educational policy.'" 102 S. Ct. at 3052, citing *San Antonio School Dist. v. Rodriguez*, 411 U.S. 1, 42 (1973).[22] Thus, the Court has discouraged the imposition of obligations on federal funds recipients that go beyond those set forth in the language of the statute. *Pennhurst State School & Hospital v. Halderman*, 451 U.S. at 24-25. *See also Southeastern Comm. College v. Davis*, which held that Section 504 on its face shows that Congress did not intend to impose an affirmative action requirement on federal funds recipients.

The decided cases have made clear that Section 504 was not intended to provide equal *results* to all classifications of handicapped individuals. Congress provided that "if the handicapped are given *access* to medical care

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[21] The Court further stated that the statute "generates no additional requirement that the services so provided be sufficient to maximize each child's potential 'commensurate with the opportunity provided other children.'" 102 S. Ct. at 3046.

[22] See also Beal v. Doe, 432 U.S. 438, 444-45 (1977) (States have broad discretion in determining the amount of medical assistance and it was not unreasonable for the state to exclude nontherapeutic abortions from Medicaid); Pennhurst State School & Hospital v. Halderman, 451 U.S. 1, 24-25 (1981) (Court would not assume that Congress intended to impose massive financial obligations on the States). *See also* Furnco Const. Corp. v. Waters, 438 U.S. 567, 578 (1978) ("Courts are generally less competent than employers to restructure business practices, and unless mandated to do so by Congress they should not attempt it.").

equal to that afforded the general population, no discrimination will be found." *NAACP v. Wilmington Medical Center, Inc.*, 491 F. Supp. 290, 318 (D. Del. 1980), *aff'd*, 657 F.2d 1322 (3d Cir. 1981) (emphasis added). *See also Doe v. Coalutti*, 592 F.2d 704, 707-10 (3d Cir. 1979) (Congress conferred broad discretion on the States in determining Medicaid assistance. Section 504 was not violated by denial of hospitalization in private psychiatric institutions beyond 60 days); *Doe v. Devine*, 545 F. Supp. 576, 585 (D.D.C. 1982), *aff'd*, 703 F.2d 1319 (D.C. Cir. 1983) (Mental health cutback does not violate Section 504 since program "will restore physically and mentally ill persons to relative equivalency in terms of actual resource expenditures. Thus, there can be no genuine contention that the cutbacks at issue 'discriminate' against mentally diseased persons solely by virtue of their handicaps."); and *Bernard B. v. Blue Cross & Blue Shield*, 528 F. Supp. 125, 132-33 (S.D.N.Y. 1981), *aff'd*, 679 F.2d 7 (2d Cir. 1982) (Exclusion of psychiatric inpatient care did not constitute discrimination solely because of handicap.)

In light of the above cases, it cannot be seriously argued that Section 504 is violated by providing equal hospital services to all categories of persons in need of hospitalization. Such equal treatment can in no way be considered discrimination solely on the basis of handicap. To read Section 504 in the manner of the Sixth Circuit would impose obligations on local governments that finds no support in the statutory language or its legislative history. Moreover, to do so would mean that once local governments have established a certain level of funding for programs affecting the handicapped they never can be reduced because of the inevitable impact on some group of handicapped individuals. Without clear indication from Congress, these additional burdens cannot be placed upon the recipients of federal funds.

CONCLUSION

For all the reasons set forth above, the Court should vacate the decision of the Sixth Circuit below and hold that the State did not violate Section 504 when it reduced the number of reimbursed hospital days in the same amount for all eligible Medicaid recipients.

Respectfully submitted,

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No. 83-727

IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

LAMAR ALEXANDER, GOVERNOR OF THE STATE OF TENNESSEE, ET AL.,
Petitioners,

vs.

ROSIER JENNINGS, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF THE PETITIONERS, LAMAR ALEXANDER, GOVERNOR OF THE STATE OF TENNESSEE, ET AL.

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QUESTIONS PRESENTED

1. Is a "disparate impact" or "effects" test appropriate to determine a violation of § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and regulations promulgated thereunder?

2. In the alternative, when the Tennessee Medicaid Program provides equal hospital services to the handicapped and nonhandicapped of fourteen (14) days per year, per recipient, does such a limit constitute a "disparate impact" or prima facie violation of § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and regulations promulgated thereunder, when the limit will satisfy all needed hospital care for 95% of the eligible handicapped recipients?

LIST OF PARTIES

The following parties appeared in the Court of Appeals:

Rosier Jennings b/n/f; Kathleen Jennings; Hershel Choate; Wilma Ann Hyder; Clyde Vaughn b/n/f; Edith Vaughn; Paul Ramone Parsons b/n/f; Lou Ann Bradley; Rebecca West; Paulette West; Michaelle Ogle b/n/f; Lind Sue Ogle; Eldon Kerr; Stella Karris; Sadie I. Owens; Margaret Betty; Charles Baldwin; Carrie Clemons,

(Plaintiffs-appellants in the Court of Appeals, Respondents in this Court).

Lamar Alexander; Eugene Fowinkle; Ben Crim; Carolyn Hale,

(Defendants-appellees in the Court of Appeals, Petitioners in this Court).

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BRIEF OF THE PETITIONERS, LAMAR ALEXANDER, GOVERNOR OF THE STATE OF TENNESSEE, ET AL.

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 715 F.2d 1036 (6th Cir. 1983) (dissenting opinion), and is set out in the Appendix to Petitioners' Petition for Writ of Certiorari at A. 1. The decision of the District Court is reported at 518 F.Supp. 877 (D.C. Tenn. 1981) and is set out in the Appendix to Petitioners' Petition for Writ of Certiorari at A. 27.

JURISDICTION

The judgment of the Court of Appeals was entered on August 4, 1983. The Petitioners, Lamar Alexander, Governor of the State of Tennessee, *et al.*, timely filed a Petition for Writ of Certiorari on October 31, 1983 and it was granted on February 21, 1984. Jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

Section 504, Title V, "Rehabilitation Act of 1973", 87 Stat. 394, as amended, 29 U.S.C. § 794:

> No otherwise qualified handicapped individual in the United States, as defined in section 706(7) of this title, shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service. The head of each such agency shall promulgate such regulations as may be necessary to carry out the amendments to this section made by the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act of 1978. Copies of any proposed regulation shall be submitted to appropriate authorizing committees of the Congress, and such regulation may take effect no earlier than the thirtieth day after the date on which such regulation is so submitted to such committees.

STATEMENT OF THE CASE

This case involves the legality of a decision by the Tennessee Medicaid Program to reduce the number of inpatient hospital days the program provides in a fiscal year to each eligible recipient from 20 to 14. At issue is whether or not this reduction

violates § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) (hereinafter § 504) and regulations promulgated thereunder. The reduction was scheduled to go into effect on August 15, 1980, along with other program reductions to ensure the continued existence of the financially-strapped Medicaid Program. The respondents, plaintiffs below, all Tennessee Medicaid recipients, filed suit on August 14, 1980 to enjoin these proposed changes. Named as defendants, petitioners in this Court, were the Governor of Tennessee and 3 other State officials responsible for administration of the Medicaid Program.

The District Court ruled that the challenged reduction did not violate § 504. The Court of Appeals reversed, holding that the reduction, though neutral on its face, had a discriminatory "effect" or "disparate impact" upon the handicapped, thus creating a prima facie violation of § 504. The Court of Appeals, therefore, remanded the case to the District Court for further proceedings to determine if the "disparate impact" could be justified.

The Tennessee Medicaid Program

The "Tennessee Medical Assistance Act of 1968", T.C.A. § 14-23-101 *et seq.*, (hereinafter Tennessee Medicaid Program) established a comprehensive scheme to provide health care services to indigent Tennessee citizens funded jointly by the State of Tennessee and the federal government under Title XIX of the Social Security Act of 1965, 79 Stat. 343, 42 U.S.C. § 1396 *et seq.*[1] During the fiscal year preceding the filing of this lawsuit, Fiscal Year (FY) 1979-80, there were 341,960 individuals enroll-

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[1] Receipt of funds under Title XIX obligates the State of Tennessee to operate its Medicaid Program in accordance with a "state plan" approved by the Secretary of Health and Human Services. 42 U.S.C. §§ 1396 and 1396a; 42 C.F.R. Part 430; Harris v. McRae, 448 U.S. 297, *reh. den.* 448 U.S. 917 (1980).

ed under various eligibility categories in the Tennessee Medicaid Program.[2] (A. 184). Medical care services available to eligible recipients covered a wide spectrum including physician services, inpatient hospital services, prescription drugs, nursing home care, laboratory services and numerous outpatient clinical services.[3] (A. 185). Although federal law and regulations under Title XIX set requirements as to *whom* and *what* type of services must be provided[4], the *level* at which a particular service is provided is left to the state as long as the service is provided in a

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[2] Federal law requires state Medicaid programs to provide benefits to individuals receiving cash assistance under certain federally-funded welfare programs. 42 U.S.C. § 1396a(a)(10)(A)(i) and 42 C.F.R. § 435.100. This includes Aid to Families with Dependent Children (AFDC), 42 C.F.R. § 435.110, and Supplemental Security Income (SSI), 42 C.F.R. § 435.120. In addition, a State *may elect* to cover "medically needy" individuals who do not get categorical assistance but are unable to pay for their own medical care. 42 U.S.C. § 1396a(a)(10)(A)(ii) and 42 C.F.R. § 435.300. When this lawsuit was filed, the Tennessee Medicaid Program covered both the "categorically needy" and the optional "medically needy" category. *See* "Defendants List of Exhibits", D-1.

[3] Federal law requires each state Medicaid program to provide six specific medical care services to the categorically needy, *inpatient hospital services*, outpatient hospital services, laboratory and X-ray services, skilled nursing facilities, physican services and certain midwife services. 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. § 1396d(a) 42 C.F.R. § 440.210. In addition to these required services, federal law and regulations, 42 U.S.C. § 1396d(a) and 42 C.F.R. § 440.1, authorize states to provide other "optional services". The Tennessee Medicaid Program at all times relevant to this suit provided both required and optional services. States may elect to provide less extensive services to "medically needy" eligibles. 42 U.S.C. § 1396a(a)(10)(C) and 42 C.F.R. § 440.220. Tennessee, however, provided equal services to both categories. T.C.A. § 14-23-107.

[4] *See* footnotes 2 and 3.

reasonable "amount, scope, and duration".[5] Even with limitations, the cost of operating the Tennessee Medicaid Program is significant. In FY 1979-80, for example, the Tennessee Medicaid Program purchased health care services for eligible recipients costing a total of $365,120,000, roughly 70% of which, or $253,515,000.00, was federal funds.[6] (A. 184).

Despite the expenditure of such large sums, the Tennessee Medicaid Program faced a fiscal crisis going into FY 1980-81. For that year, the Tennessee General Assembly appropriated in combined federal and state funds $388,000,000.00. This represented an increase of almost $26,000,000.00 over funds appropriated for the previous FY 1979-80. (A. 44). Nevertheless, Medicaid Program officials predicted that in order to provide medical services in FY 1980-81 at the same levels to the same number of individuals as in FY 1979-80 the Program needed $430,000,000.00 as opposed to the $388,000,000.00 appropriated. (A. 44). Since Tennessee law prohibited deficit

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[5] 42 C.F.R. § 440.230. At the time this action was filed in the District Court, § 440.230 provided as follows:

> (a) The plan must specify the amount and duration of each service that it provides.
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> (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
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> (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of diagnosis, type of illness or condition.
>
> (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

43 Fed. Reg. 45224, September 29, 1978.

[6] The share paid by the federal government varies from state to state in accordance with a statutorily defined formula. 42 U.S.C. § 1396b(a).

spending', Medicaid Program officials were faced with the real prospect of running out of money in March or April of 1980 and shutting the Program down altogether. (Transcript of Proceedings, August 15, 1980 p. 96).

The financial calamity facing the Tennessee Medicaid Program was not spawned by mismanagement, ballooning eligibility roles or an increase in the types of services. Rather, it was caused by the astronomical rise in health care costs which the Tennessee General Assembly refused to subsidize. From FY 1975-76 through FY 1980-81, the number of individuals enrolled in the Tennessee Medicaid Program remained relatively constant. (A. 64, 167). Likewise, the number of eligible individuals who used Medicaid services, ("users" or "recipients"), remained constant. (A. 64, 167).[8] By stark contrast, the cost of providing

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[7] Art. 2, § 24 of the Tennessee Constitution provides:

> No public money shall be expended except pursuant to appropriations made by law. Expenditures for any fiscal year shall not exceed the state's revenues and reserves, including the proceeds of any debt obligation, for that year. No debt obligation, except as shall be repaid within the fiscal year of issuance, shall be authorized for the current operation of any state service or program, nor shall the proceeds of any debt obligation be expended for a purpose other than that for which it was authorized.

T.C.A. § 14-23-109 of the Medicaid law, likewise provides:

> In no event shall the services paid for by the state including assistance from the United States government require expenditures of state funds in excess of the amount appropriated for such purpose. The commissioner may by rule and regulation fix the maximum level of services as are deemed necessary to insure that an expenditure of state funds shall not exceed the amount provided for those purposes, as approved by the commissioner of finance and administration.

[8] The distinction between "eligibles" and "recipients" or "users" must be kept in mind. The former group consists of all individuals who have been deemed eligible for services either as categorically needy or as medically needy. (*See* footnote no. 2). "Recipients" or "Users" are those eligibles who have a need for medical services and actually "pull their card out of their pocket" to pay for the service. (A. 63).

services to this static pool of individuals during the same period of time skyrocketed at an annual rate of 20% from $136,000,000.00 in FY 1975-76 to $430,000,000.00 in FY 1980-81. (A. 65, A. 167).

Thus going into the FY 1980-81, the Tennessee Medicaid Program was faced with the choice of either cutting the cost of the Program by $42,000,000.00 or running out of money. Instead of taking drastic steps such as dropping individuals not required by law to be covered or cutting optional services[9], Medicaid Program officials chose to make adjustments in the level of benefits in several program services and institute other cost-saving measures. One of these changes involved a reduction in the number of inpatient hospital days Medicaid would pay hospitals on behalf of a recipient from 20 per fiscal year to 14 per fiscal year.[10] It was anticipated that this change alone would save the Program almost $13,000,000.00. (A. 68). All of the changes were scheduled for implementation at midnight on August 15, 1980.[11] (Transcript of Proceedings August 15, 1980 p. 65). The respondents filed suit on August 14, 1980. (A. 1).

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[9] *See* footnotes 2 and 3.

[10] Since its inception in 1969, the Tennessee Medicaid Program had provided 20 days of inpatient hospital care per fiscal year. Why the limit of 20 days was established is not clear. Federal law and regulations do not require State programs to provide any specific number of days as long as the limit is reasonable in "amount, duration, and scope". (*See* footnote 5). The number of inpatient hospital days covered will vary from state to state depending on several factors, including what other services are provided by a Program. Some states provided more inpatient days than Tennessee and others less. (A. 66-67).

[11] The other proposed reductions included: deletion of certain drugs from the list of prescription drugs paid for by Medicaid; limitation of the number of "outpatient" hospital visits allowable per year to each Medicaid recipient; reduction in the rate of reimbursement to physicians; limitation on the number of nursing home beds certified to care for Medicaid recipients. (Transcript of Proceedings, August 15, 1980 pp. 65-90). In addition, several changes were made in the manner in which hospitals were *reimbursed* for inpatient care. (A. 69-70).

Proceedings in the District Court

Respondents' Original and Amended Complaints, seeking declaratory and injunctive relief and filed August 14, 1980 and August 15, 1980 respectively, challenged the validity of virtually all the proposed cost-saving program changes on numerous procedural and substantive grounds. (A. 4). By the time of trial disputes with respect to all but two of the changes had been resolved, the change in covered inpatient hospital days and the pharmacy changes. The pharmacy issue was settled subsequent to trial, but prior to to the District Court's final decision of June 17, 1981. (A. 2). With respect to the change in the number of inpatient hospital days allowed each eligible recipient in a fiscal year, from 20 to 14, the respondents at trial attacked it on four grounds, one of which was that it discriminated against the handicapped in violation of § 504.

Impact on the Handicapped

Based upon evidence presented at trial, (A. 170, 172, and 184), the District Court properly found that during the preceeding fiscal year of 1979-80, there were 341,960 persons eligible to receive Medicaid services in Tennessee. Of this number, 90,668 were classified as handicapped and 16, 852 of them used one or more hospital days. Of the remaining 251,292 nonhandicapped recipients, 34,288 were in the hospital for one or more days during the study year. *Jennings v. Alexander*, 518 F.Supp. 877, 880 (D.C. Tenn. 1981); (Appendix to Petitioners' Petition for Certiorari, A. 31-32).

In order to establish the impact of a 14-day limitation on the handicapped, several studies were prepared by the Medicaid Program to determine the effect of the limitation had it been in place during FY 1979-80. (A. 168, 179).[12] Two tables in one

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[12] Both studies were based on an analysis of all claims for inpatient hospital services paid by the Tennessee Medicaid Program during the FY 1979-80. "Defendants' List of Exhibits", D-4(j) through D-4(s). One study was prepared by the EDS-Federal Corporation, a private

study, "Table 1", (A. 170), and "Table 3", (A. 172), formed the primary basis of the Court's findings. "Table 1" deals with *all* users of inpatient hospital services during FY 1979-80. It breaks down the number of users by the level of days used *i.e.*, how many users used 3 days, 4 days, 10 days, etc.[13] It also shows the *number* of users who would not have had all their inpatient hospital days paid for by Medicaid and the *percentage* of users who would have had all their inpatient needs covered if the limit had been 19, 18, 17, 16, 15, and 14 days.[14] "Table 3" provides the same data, though in a different format, as to the *handicapped* users of inpatient hospital services in FY 1979-80[15].

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firm on contract with the State of Tennessee to process Medicaid claims. (A. 168, A. 71). The second study was prepared by Dr. W. K. Vaughn, Director of the Division of Bio-Statistics at Vanderbilt University School of Medicine in Nashville, Tennessee. (A. 179, A. 90).

[13] The unusually large number of users ranked at the 20-day level is due to the fact that hospitals billed the program for no more than 20 days, it being the cap on reimbursement. Therefore, grouped at 20 days are users of 21 days and beyond. (A. 74).

[14] For example, under the "Cumul. Users Affected" column, it reveals that 7,279 users of inpatient hospital services used more than 14 days. This figure is calculated by *adding* the number of users at the 20, 19, 18, 17, 16, and 15 day levels. (A. 75). Under the "Percentage Users Served" column, it reveals that had the 14-day limit been in place in the study year, 92.56% of *all* users of inpatient hospital services would have had all their needs met by Medicaid. (A. 77). The formula used to arrive at this percentage is set forth on the table.

[15] Thus, according to "Table 3", the 14-day limit still would have met all the needed care of 84.4% of the handicapped users. This would leave only 4,617 users not having all their needs met. (A. 78).

Based on this data, the District Court properly concluded:

> [The evidence]. . .showed that for the fiscal year examined, 72.6% of the handicapped users would have been fully served by 14 days of hospital inpatient coverage. Stated otherwise, 27.4% of all handicapped users in 1979-80 needed more than 14 days of inpatient hospital treatment. By contrast, 92.2% of all nonhandicapped users were fully served at 14 days or less, leaving only 7.8% in need of inpatient hospital care beyond the 14th day. *Id.* at 881. (Appendix to Petitioners' Petition for Certiorari, A. 32)[16]

Based on its own calculations, the Court also found as follows:

> Indeed, the actual impact of the proposed limitation, even in the study year, should be kept in perspective. Since only 18.586% of handicapped eligibles used any inpatient hospital services, and 27.4% of those needed more than 14 days, only about 5% of the handicapped eligibles were in need of more than 14 days of hospital treatment. Thus, 95% would have been fully served at 14 days. *Id.* at 882, n. 6; (Appendix to Petitioners' Petition for Certiorari, A. 32).

The District Court, therefore, properly concluded that the proposed reduction in the number of inpatient hospital days did not violate § 504. While agreeing that a "disparate impact" test

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[16] The statistical findings of the District Court vary somewhat from the calculations on the face of "Table 1" and "Table 3" for two (2) reasons. First, in using the formula to calculate the percentage of users served, the District Court subtracted from the "total users" figure on each table the "Medicare/Medicaid" users. For these individuals, all the Tennessee Medicaid Program does is pay their "Medicare" deductible for hospital care. Neither the 20 nor 14 day limitation would effect the number of days paid under "Medicare". Second, the District Court converted the figures on "Table 1" reflecting "all" users into a "nonhandicapped" users table. Essentially figures on "Table 3" reflecting the number of handicapped users were subtracted from the figures on Table 1. These calculations are set out in the record. (A. 81-88).

was appropriate, the Court found that the alleged adverse effect of the reduction on the handicapped simply did not rise to the level of a "disparate impact". *Id.* at 885; (Appendix to Petitioners' Petition for Certiorari, A 40). In so ruling, the Court held that § 504 was never intended to ensure equality of results but only equal access by the handicapped to programs such as Medicaid. *Id.;* (Appendix to Petitioners' Petition for Certiorari, A 42-43). The Court carefully distinguished the present case from those cases where the alleged "disparate impact" amounted to an outright exclusion of the handicapped from the service or benefit in question. *Id.* at 883-884; (Appendix to Petitioners' Petition for Certiorari, A 36-40).

Proceedings in the Court of Appeals

On appeal, a three-judge panel of the Sixth Circuit Court of Appeals, Judge Merritt dissenting, reversed the District Court ruling and remanded the case for further proceedings. *Jennings v. Alexander,* 715 F.2d 1036 (6th Cir. 1983); (Appendix to Petitioners' Petition for Certiorari, A. 1). The Court of Appeals ruled that a "disparate impact" test was appropriate for determining a violation of § 504.[11] The Court of Appeals, however, contrary to the District Court, found that the 20 to 14-day reduction, based on the data in the record, constituted a discriminatory "effect" upon the handicapped. The Court of Appeals found such "effect" solely on the fact that 92.2% of all nonhandicapped who needed hospital care would have all their needs met at a 14-day limit as opposed to 72.6% for the handicapped. Accordingly, the Court of Appeals reversed the

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[11] In general, this test allows a plaintiff to establish a "prima facie" violation of § 504 if he can show that an activity, though unintentional and facially neutral, has a discriminatory "effect" upon the handicapped as opposed to the nonhandicapped. If a discriminatory "effect" is made out, then the burden shifts to the defendant to justify the disparity of treatment as necessary to achieve a legitimate goal of the activity under scrunity. *See Bryan v. Koch,* 627 F.2d 612 (2nd Cir. 1980).

District Court and remanded the case for further proceedings to determine if the defendant Medicaid officials could rebut the prima facie violation of § 504.

Judge Merritt, in a vigorous dissenting opinion, found no discrimination in the fact that "some" handicapped will be more adversely effected than the nonhandicapped. *Id.* at 1047; (Appendix to Petitioners' Petition for Certiorari, A 21). He saw the majority opinion as having turned the "effects" test under § 504 into a results test requiring federally-funded programs and services to be equally efficacious in their results to the handicapped and nonhandicapped alike. *Id;* (Appendix to Petitioners' Petition for Certiorari, A 22). Judge Merritt was also of the opinion that an "effects" standard should not have been applied in this case. *Id.*, at 1049; (Appendix to petition for Certiorari, A. 25).

SUMMARY OF ARGUMENT

Congress only intended to prohibit *intentional* discrimination when it enacted § 504, prohibiting discrimination of the handicapped in federally funded programs. This intent is most clearly demonstrated in the language of § 504 which is almost identical to Title VI of the Civil Rights Act of 1964 which prohibits discrimination of minorities in federally funded programs. *Consolidated Rail Corporation v. Darrone,* No. 82-862, February 28, 1984. With respect to Title VI, this Court has conclusively held that it bars only intentional discrimination. *Regents of the University of California v. Bakke,* 438 U.S. 265 (1978). *Guardians Association v. Civil Service Commission of the City of New York,* No. 81-431, July 1, 1983. If Congress intended to prohibit unintentional discriminatory *effects* under § 504, it would have made its intent clear in the language or history of § 504 as in other laws prohibiting discrimination. *See, e.g., Griggs v. Duke Power Company,* 401 U.S. 424, 432 (1971). *Board of Education, New York City v. Harris,* 444 U.S. 130, 140 (1979).

A ruling that § 504 prohibits only intentional discrimination is consistent with the narrow purpose of § 504 which is to ensure the even-handed treatment of the handicapped in federally funded programs and not affirmative action to overcome disabilities caused by handicaps. *Southeastern Community College v. Davis,* 442 U.S. 397, 410 (1979). A contrary ruling would attribute to Congress the unlikely intent to afford greater protection to the handicapped under § 504 than minorities protected under Title VI.

Since § 504 prohibits only intentional discrimination, implementing regulations thereunder can only prohibit intentional discrimination. *Guardians Association v. Civil Service Commission of New York,* No. 81-431, July 1, 1983, (opinion of O'CONNOR, J); *Bratterton v. Francis,* 432 U.S. 416, 426 (1977); *Mourning v. Family Publication Services, Inc.,* 411 U.S. 356, 369 (1973). Petitioners recognize, however, that in *Guardians Association v. Civil Service Commission of New York, supra,* (STEVENS, BRENNAN and BLACKMUN), three justices upheld regulations under Title VI prohibiting discriminatory "effects" despite their finding that Title VI prohibited only intentional discrimination. They did so upon a belief that the regulations "furthered" the purpose of Title VI. An effects standard under § 504, however, is a false indicator of handicapped discrimination. This is due to the diverse nature of the class of individuals constituting the handicapped and their reliance on a wide variety of programs. Any changes in such programs will almost always adversely impact on some group of handicapped more than the nonhandicapped. As such, regulations incorporating an "effects" standard do not further the purpose of § 504.

Even if § 504 or implementing reguiations prohibit unintentional discriminatory effects, the Court of Appeals erred in finding a prima facie violation of § 504 in this case. There is simply no proof that a reduction in the number of inpatient hospital

days provided each Tennessee Medicaid recipient per year would have a disparate impact on the handicapped. Both the handicapped and nonhandicapped would have 14 days of care available to them. At this level, 95% of the *eligible* handicapped would have all their inpatient hospital needs met. *Jennings v. Alexander*, 518 F.Supp. at 882 n. 6.

The Court of Appeals mistakenly found a disparate impact or prima facie violation of § 504 in the fact that fewer handicapped users of inpatient hospital services would have all their needs met at 14 days than the nonhandicapped users of the service. Under the Court of Appeals' interpretation, § 504 must not only guarantee equal access of the handicapped to federally funded programs, but must also guarantee equality of results. Regulations implementing § 504 preclude such an interpretation. 45 C.F.R. § 84.52(a)(3) and 45 C.F.R. § 84.4(b)(2). Furthermore, requiring federally funded programs to meet all the needs of the handicapped would "obliterate" the ability of the states to set reasonable limits on program services otherwise authorized by law. *Doe v. Colautti*, 592 F.2d 704, 710 (3rd Cir. 1979).

ARGUMENT

I. A Violation Of § 504 Or Regulations Promulgated Thereunder Requires Proof Of "Intentional" Discrimination.

A. Congress Only Intended To Prohibit Intentional Discrimination Under § 504.

Section 504 provides, in pertinent part, as follows:

> No *otherwise qualified* handicapped individual in the United States, as defined in section 706(7) of this title, shall, *solely by reason of his handicap*, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. . . .[18] (Emphasis supplied).

A unanimous Court in *Southeastern Community College v. Davis*, 442 U.S. 397, 410 (1979) held that the purpose of § 504 was simply to ensure the even-handed treatment of qualified handicapped persons in federally funded programs and *not* affirmative action to overcome the disabilities caused by handicaps.[19] The carefully drawn language of § 504 and its narrow

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[18] Section 504, Title V, "Rehabilitation Act of 1973", 87 Stat. 394, as amended by Section 119, Title IV, "Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978", 92 Stat. 2982, 29 U.S.C. § 794. The "Rehabilitation Act of 1973" and its 1978 amendments represent a comprehensive effort on the part of Congress to coordinate and enhance the efforts of the federal government to assist and rehabilitate the handicapped. Section 504 is a very small part of this multifaceted law. The extremely sparse legislative history dealing specifically with § 504 and its subsequent amendment in 1978, is silent as to the nature of the discrimination prohibited thereunder. *See e.g.*, S. Rep. 93-318, 93rd Cong., *reprinted in* U.S. Code Cong. & Admn. News, 1973 p. 2076; H. R. Rep. 95-1149, 95th Cong., *reprinted in* U.S. Code Cong. & Admn. News, 1978 p. 7312.

[19] In *Davis*, the Court ruled, *inter alia*, that Southeastern Community College in North Carolina did not have an affirmative duty either under § 504 or implementing regulations to lower its admission standards and modify its existing instructional plan to accommodate the special needs of a deaf applicant.

purpose is consistent with Congress' intent to limit violations of § 504 to intentional discrimination.

This intent is most clearly demonstrated in the similarity of § 504 to language found by this Court to prohibit only intentional discrimination. The operative language of § 504 prohibiting discrimination of the handicapped in federally-funded programs is virtually identical to that found in Title VI of the "Civil Rights Act of 1964" prohibiting discrimination of minorities in federally-funded programs.[20] *Consolidated Rail Corporation v. Darrone,* No. 82-862, February 28, 1984. With respect to Title VI, *Regents of the University of California v. Bakke,* 438 U.S. 265 (1978) and *Gaurdians Association v. Civil Services Commission of the City of New Yor .,* No. 81-431, July 1, 1983, leave no doubt that when Congress enacted Title VI in 1964, its intent *at that time* was to prohibit only discrimination prohibited under the Fifth and Fourteenth Amendments to the United States Constitution. Since *Washington v. Davis,* 426 U.S. 229 (1976) had previously established that the Fifth and Fourteenth Amendments prohibited only intentional discrimination, the effect of *Bakke* was to limit discrimination prohibited under Title VI to intentional discrimination. One reason given for adopting a "constitutional" standard is that Congress intended the meaning of Title VI to "evolve" with the interpretation of the commands of the Constitution. 438 U.S. at 340. (BRENNAN, WHITE, MARSHALL, and BLACKMUN). Therefore, when Congress enacted § 504 in 1973 in the mirror image of Title VI, without qualification, it locked the nature of the discrimination prohibited by § 504 into the same evolving constitutional standards. Accordingly, intentional discrimination must be shown to prove a violation of § 504.

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[20] Section 601 of Title VI of the "Civil Rights Act of 1964", 78 Stat. 252, 42 U.S.C. § 2000d provides:

> No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

In sharp contrast to the language and history of § 504 and Title VI are similar statutory schemes where Congress expressed its intent to prohibit the unintentional effects of discrimination. Section 703 of Title VII of the "Civil Rights Act of 1964", for example, makes it unlawful for an employer to treat his employees:

> . . . in any way which would deprive or *tend to deprive* any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's race, color, religion, sex or national origin. 78 Stat. 255, 42 U.S.C. § 2000e-2. (Emphasis supplied).

In *Griggs v. Duke Power Company,* 401 U.S. 424, 432 (1971), Title VII was interpreted as expressing Congress' intent to eradicate the "*consequences*" of discriminatory employment practices without regard as to whether or not they were intentional. Likewise, in *Board of Education, New York City v. Harris,* 444 U.S. 130, 141 (1979), the Court had little trouble in finding that Congress intended to prohibit unintentional discrimination in the assignment of public school teachers under § 706(d)(1)(B) of the 1972 Emergency School Aid Act, 86 Stat. 358, 20 U.S.C. § 1605(d)(1)(B). Though the language of the Act was somewhat ambiguous, the Court concluded:

> The overall structure of the Act, Congress' statements of purpose and policy, the legislative history, and the text of § 706(d)(1)(B) *all* point in the direction of an impacts test. *Id.* (Emphasis supplied).

If Congress had intended to prohibit anything other than intentional discrimination under § 504 it would have expressed such an intent as it has done in these instances.

Finally, a holding that § 504 can be violated upon proof of unintentional discriminatory effects, while Title VI imposes a stricter burden of discriminatory "intent", would attribute to Congress a desire to afford greater protection to the handicap-

ped than minorities protected by Title VI. There is no evidence of such a legislative purpose nor would it seem likely absent some clear expression to the contrary.[21]

B. Since § 504 Prohibits Only Intentional Discrimination, Regulations Promulgated Thereunder Can Only Prohibit Intentional Discrimination.

A holding that § 504 prohibits only intentional discrimination should preclude any futher discussion as to a less vigorous effects standard being applied under implementing regulations. It is generally recognized that administrative regulations cannot go beyond the statute they interpret or implement. *Guardians Association v. Civil Service Commission of New York,* No. 81-431, July 1, 1983 (opinion of O'CONNOR, J.); *Bratterton v. Francis,* 432 U.S. 416, 426 (1977); *Mourning v. Family Publication Services, Inc.,* 411 U.S. 356, 369 (1973).

Petitioners recognize, however, that three members of the Court in *Guardians Association v. Civil Service Commission of New York, supra,* (STEVENS, BRENNAN and BLACKMUN), while holding that a violation of Title VI required a showing of discriminatory "intent", nevertheless held that implementing regulations promulgated thereunder could prohibit unintentional discriminatory "effects". This holding was based on the belief that effects regulations "furthered" the ultimate purpose of Title VI. Given the similarity of Title VI and § 504 and their implementing regulations, one might be tempted to conclude that regulations implementing § 504 could also impose an effects standard. The petitioners submit that a similar holding in this case would be inappropriate.

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[21] From a constitutional perspective, the class of individuals covered by Title VI are suspect classifications, and afforded a much greater degree of protection than non-suspect classifications such as the handicapped. *Compare, Loving v. Virginia,* 388 U.S. 1 (1967) with *California Association of Physically Handicapped v. F.C.C.,* 721 F.2d 667, 670 (9th Cir. 1983).

It is questionable whether any imlementing regulations under § 504 adopting an "effects" standard can be a true indicator of handicapped discrimination. This is so because the class of handicapped persons protected by § 504 is far from a homogeneous group. It is composed of individuals with a multitude of handicapping conditions of varying degree who rely on an equally diverse set of federally funded social services. A reduction or limitation in any one of these services will undoubtedly have an adverse impact on *some* goup of handicapped individuals to a greater degree than the nonhandicapped or some other group of handicapped. An "effects" analysis in these circumstances will almost always produce a finding of some form of disparate impact. Yet it would be erroneous to conclude, as did the Sixth Circuit in this case, that these situations constitute a prima facie violation of § 504.

Judge Merritt in his dissenting opinion stated the problem in these terms:

> It is highly questionable whether a disparate impact test should be applied under § 504. This case appears to be the first federal appellate court opinion which actually finds discrimination against the handicapped by applying a 'disparate impact' test.
>
> . . .
>
> Assuming *arguendo* the applicability of a disparate impact test, this case illustrates why such a test will not work unless a *bright-line equality of access standard is used. Combining an equality of results standard with a disparate impact test means the plaintiff always wins.*
>
> According to the majority's interpretation of the statute. . . there are many sub-classes of patients who fall within the 'handicapped' category, not just traditional groups like the blind, the deaf and the lame.
>
> . . .

> Any reduction in funding or services will have a differential impact on some class of patients. In such a situation the disparate impact test will always work for some class of illness; it will always produce a finding of discrimination.

Jennings v. Alexander, 715 F.2d at 1049; (Appendix to Petitioners' Petition for Certiorari, A. 25).

Congress was obviously aware of the difficulties in isolating discriminatory activities when it prohibited discrimination of the handicapped under § 504 "solely by reason of. . . handicap". Likewise, when the then-Secretary of Health, Education, and Welfare first promulgated § 504 regulations, he expressed the difficulty in dealing with handicapped discrimination in federally funded programs:

> From the outset, the Department has recognized that the problem of ending discrimination on the basis of handicap presents considerations that are extremely complex. The diversity of types of handicaps, as well as the wide variety of settings in which programs financed by the Department are offered, make the task of prescribing general rules of non-discriminatory treatment a difficult one.

42 Fed. Reg. 22676, May 4, 1977. Indeed, the Department did not initiate procedures to enact regulations for almost three years after passage of § 504, relying soley on the general prohibition of the statute. *Cherry v. Mathews,* 419 F.Supp. 922 (D.D.C. 1976).

II. Even If A "Disparate Impact" Or "Effects" Standard Is Appropriate To Determine A Violation Of §504, There Is No Proof In This Case Of A Disparate Impact On The Handicapped.

Alternatively, the petitioners argue that even if actions which unintentionally discriminate against the handicapped can constitute violations of § 504, it does not relieve the complaining party of its burden of proving discrimination. Accordingly, to

establish a prima facie violation of § 504, even under a "disparate impacts" test, it requires proof that the handicapped have been excluded or otherwise denied access to a service or benefit afforded the nonhandicapped.[22] There is no such proof in this case. Both handicapped and nonhandicapped Tennessee Medicaid recipients would have access to 14 inpatient hospital days per year. As correctly calculated by the District Court, 95% of all "eligible" handicapped Medicaid recipients would have all of their inpatient hospital needs met at the 14-day limitation. *Jennings v. Alexander,* 518 F.Supp. at 882, n. 6; (Appendix to Petition for Certiorari, A. 34). There is no other evidence in this case to demonstrate that the 14-day limitation would render inpatient hospital services for the handicapped ineffective, inaccessable, or otherwise a constructive nullity.

The only disparity between the handicapped and nonhandicapped revealed in this record is that the 14-day limitation would satisfy all inpatient hospital needs of a smaller percentage of handicapped recipients than nonhandicapped recipients. The fact that some handicapped recipients may require more inpatient hospital services by virtue of their handicaps when compared to the nonhandicapped, is an imbalance which the Tennessee Medicaid Program does not have to accommodate under § 504. Any thought to the contrary was laid to rest by this Court's holding in *Southeastern Community College v. Davis, supra,* at 410-411. Likewise, § 504 implementing regulations governing the Tennessee Medicaid Program dispell any such notion.

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[22] The decisions of this Court are in accord: *Guardians Association v. Civil Service Commission of the City of New York, supra* (unintentional exclusion of minorities from municiple employment); *Board of Education v. Harris, supra,* (unintentional exclusion of minority public school teachers from certain teaching assignments); *Lau v. Nichols,* 414 U.S. 563 (1974) (unintentional exclusion of minority students from meaningful access to public education); and *Griggs v. Duke Power Company, supra* (unintentional exclusion of minorities from certain job classifications).

45 C.F.R. § 84.52(a)(3) of the regulation of the Department of Health and Human Services[23] implementing § 504 and applicable to the Tennessee Medicaid Program provides:

> (a) . . . In providing health, welfare, or other social services or benefits, a recipient may not, on the basis of handicap:
>
> . . .

---

[23] 42 Fed. Reg. 22677, May 4, 1977; 45 C.F.R. Part 84 . The regulations address handicapped discrimination in both general terms and in the context of specific types of programs and services. Section 84.52(a) of Subpart F, dealing with "Health, Welfare, and Social Services", provides in full:

> (a) General. In providing health, welfare, or other social services or benefits, a recipient may not, on the basis of handicap:
>
> (1) Deny a qualified handicapped person these benefits or services;
>
> (2) Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered nonhandicapped persons;
>
> (3) Provide a qualified handicapped person with benefits or services that are not as effective (as defined in § 84.4(b)) as the benefits or services provided to others;
>
> (4) Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons; or
>
> (5) Provide different or separate benefits or services to handicapped persons except where necessary to provide qualified handicapped persons with benefits and services that are as effective as those provided to others.

Other than subsection (a)(3), the prohibitions of this section are not at issue in this case. They all deal with questions of "access" by the handicapped to aids, benefits or services. There is no argument in this case that the handicapped have been denied access to inpatient hospital services.

> (3) Provide a qualified handicapped person with benefits or services that are not as effective (*as defined in* § 84.4(b)) as the benefits or services provided to others; (Emphasis supplied).

This prohibition is dramatically qualified by 45 C.F.R. § 84.4(b)(2) which provides:

> For purposes of this part, *aids, benfits, and services, to be equally effective, are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons, but must afford handicapped persons equal opportunity to obtain the same result,* to gain the same benefit, or to reach the same level of achievement, in the most integrated setting appropriate to the person's needs. (Emphasis supplied).

These regulations, properly construed, require only that aids, benefits and services, be provided in like kind to both the handicapped and nonhandicapped. Applied to the number of inpatient hospital days provided by the Tennessee Medicaid Program, the regulations only require that the same amount be extended to the handicapped as to the nonhandicapped. In order to violate these regulations one must intentionally designate a lesser amount to be provided the handicapped than the nonhandicapped.

By going beyond the actual requirements of § 504, the Court of Appeals has established an unprecedented "effects" standard for determining discrimination of the handicapped.[24] No

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[24] It could be argued that this standard applies in Title VI cases as well. In its opinion, the Court of Appeals viewed tests for determining a violation of § 504 and Title VI to be identical:

> Section 504 is "part of the general corpus of discrimination law". *New York State Association for Retarded Children v. Carey,* 612 F.2d 644 (2d Cir. 1979). It is predicated on Title VI of the Civil Rights Act, 42 U.S.C. § 2000d, and is intended to prohibit the expenditure of public funds in programs that

longer must an actual discriminatory impact be shown to support a prima facie violation of § 504, but merely that a program *in some manner* is less efficacious to the handicapped than the nonhandicapped. To avoid a prima facie violation of § 504 under this standard. a program will have to ensure equal efficacy. Where the handicapped are proportionally greater users of a program service, equal efficacy will only be obtained at limits which will satisfy all the needs of the handicapped. For example, under the Sixth Circuit rationale, there is nothing to prevent the District Court on a remand of this case from finding a prima facie violation of § 504 at the *20-day* inpatient hospital day limit. All the Court need find at the 20-day limit is a disparity similar to the one found at the 14-day limit. The Tennessee Medicaid Program would then have to justify why the limit should not be pushed upwards of 20 days.

Further, if § 504 requires federally funded services to be provided at levels to satisfy all the needs of the handicapped, it "obliterates" other reasonable and discretionary limits which may be placed on such programs. *Doe v. Colautti,* 592 F.2d 704, 710 (3rd Cir. 1979).[25] In this case, federal regulations governing the Tennessee Medicaid Program require only that inpatient

---

discriminate against the handicapped. *See* Sen. Rep. 1297, *supra.* Courts have generally applied the same tests of discrimination law to Section 504 as are applied to Title VI.

Jennings v. Alexander, 715 F.2d at 1041.

[25] In *Colautti,* a Medicaid recipient in a private psychiatric hospital challenged Pennsylvania's 60-day per year limit under § 504. He argued that the limit discriminated against the mentally ill handicapped because no such limit was placed on "private general hospital" services. The Third Circuit affirmed the District Court's denial of a preliminary injunction for failure to demonstrate any likelihood of success on the merits. The Court ruled, *inter alia,* that the 60-day limit was in line with the Medicaid law and regulations and that to apply § 504 to defeat the Pennsylvania limitation would "obliterate" distinctions made by the Medicaid law in what a state was required and not required to provide recipients. *Id.* at 710.

hospital services be provided in an "amount, scope and duration to reasonably achieve its purpose". 42 C.F.R. § 440.230. (*See* n. 5). Section 504 must be read in *pari materia* with such regulations. When done so, it is again clear that § 504 does not require federally funded programs to meet all the demands of the handicapped but only to eliminate discrimination against the handicapped.

Finally, the majority opinion of the Sixth Circuit constitutes an unwarranted intrustion into the state's budgetary process by creating a whole new source of challenges to limitations placed by states on their federally funded social welfare programs. *Jennings v. Alexander,* 715 F.2d at 1047 (MERRIT dissenting). The relative ease with which a prima facie violation of § 504 can be found under the Sixth Circuit's standard almost guarantees the plaintiff a preliminary injunction and a trial on the merits at which the defendant will be required to justify its actions. This diverts § 504 from Congress' intended purpose of ensuring even-handed treatment of the handicapped into a ready tool for litigants eager to thwart reductions in federally funded social welfare programs.

CONCLUSION

For reasons set forth above, the Petitioners respectfully request that the decision of the Sixth Circuit Court of Appeals be reversed.

Respectfully submitted,

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No. 83-727

In the Supreme Court of the United States

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v.

ROSIER JENNINGS, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTION PRESENTED

The United States will address the following question:

Whether a 14-day annual limit on Medicaid coverage for inpatient hospital care has a "disparate impact" on the handicapped if a disproportionate number of handicapped Medicaid-eligible hospital users require more than 14 days of such care.

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INTEREST OF THE UNITED STATES

The United States has substantial responsibility for enforcing Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) in connection with federally assisted programs and activities.[1] This case concerns the interpretation of that Section and its implementing regulations,[2]

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[1] In 1976 the President directed the Secretary of Health, Education, and Welfare to "establish standards for determining who are handicapped individuals and guidelines for determining what are discriminatory practices, within the meaning of section 504." Exec. Order No. 11,914, 41 Fed. Reg. 17871 (1976). The Secretary issued detailed regulations. 45 C.F.R. Pt. 85 (1978). In 1980 the Secretary's responsibility was transferred to the Attorney General (Exec. Order No. 12,250, 45 Fed. Reg. 72995 (1980)), and the regulations were "deemed to have been issued by the Attorney General." *Id.* at 72997; see 28 C.F.R. Pt. 41. The regulations require each federal agency to issue its own regulations concerning handicap discrimination in the programs and activities financially assisted by that agency. 28 C.F.R. 41.4.

[2] At least 24 federal agencies have regulations which incorporate a "disparate impact" test. See 5 C.F.R. 900.704(b)(3) (OPM); 7

and the outcome will directly affect the actions of numerous federal agencies and recipients of federal funds. For the same reason, the United States has participated as amicus curiae in other cases before this Court involving Section 504. See *Southeastern Community College* v. *Davis*, 442 U.S. 397 (1979); *University of Texas* v. *Camenisch*, 451 U.S. 390 (1981); *Consolidated Rail Corp.* v. *Darrone*, No. 82-862 (Feb. 28, 1984).

STATEMENT

1. This suit was brought by Medicaid recipients from the State of Tennessee to challenge an array of changes proposed by the State to control its Medicaid expenditures. By the time of the district court's decision (Pet. App. A27-A51), the only remaining issue was the validity of Tennessee's proposed reduction in the number of hospital days covered by Medicaid from 20 to 14 per year. Although the validity of this proposed reduction was challenged on several grounds, the questions presented on certiorari concern its propriety only under Section 504 of the Rehabilitation Act.[3]

At trial, statistical evidence was submitted comparing inpatient hospital use by individuals who qualify for Medicaid benefits on the basis of blindness or disability (deemed "handicapped" by the parties and by the court

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C.F.R. 15b.4(b)(4) (DOA); 10 C.F.R. 4.121(b)(4) (NRC); 10 C.F.R. 1040.63(b)(4) (DOE); 14 C.F.R. 1251.103(b)(5) (NASA); 15 C.F.R. 8b.4(b)(4) (DOC); 18 C.F.R. 1307.4(b)(3) (TVA); 22 C.F.R. 142.4(b)(4) (DOS); 22 C.F.R. 217.4(b)(4) (AID/IDCA); 28 C.F.R. 41.51(b)(3), 42.503(b)(3) (DOJ); 29 C.F.R. 32.4(b)(4) (DOL); 31 C.F.R. 51.52(b)(1)(vi), 51.55(b)(1)(viii) (D. Treas. (ORS)); 32 C.F.R. 56.8(a)(6) (DOD); 34 C.F.R. 104.4(b)(4) (D. Ed.); 38 C.F.R. 18.404(b)(4) (VA); 49 Fed. Reg. 1656 (1984) (to be codified at 40 C.F.R. Pt. 7) (EPA); 41 C.F.R. 101-8.303(d) (GSA); 43 C.F.R. 17.203(b)(4) (DOI); 45 C.F.R. 84.4(b)(4) (HHS); 45 C.F.R. 605.4(b)(4) (NSF); 45 C.F.R. 1151.17(c) (NEA); 45 C.F.R. 1170.12(c) (NEH); 45 C.F.R. 1232.4(b)(3) (ACTION); 49 C.F.R. 27.7(b)(4) (DOT).

[3] Respondents argued below that the proposed reduction also violated the Social Security Act and its implementing regulations (Pet. App. A43-A51).

(J.A. 40)) with inpatient hospital use by individuals who qualify for Medicaid benefits on the basis of other considerations (deemed "nonhandicapped").[4] The district court found that during fiscal year 1979-1980, 341,960 persons qualified for Medicaid benefits in Tennessee. Of these 90,668 (26.5%) were handicapped. During the same period 51,140 Medicaid recipients used one or more days of inpatient hospital care. Of these 16,852 (33.0%) were handicapped (Pet. App. A31-A32).[5] Out of the 7279 Medicaid recipients who needed more than 14 days of hospital care, 4617 (63.4%) were handicapped (J.A. 170-172, 182-184).

Looking at those figures another way, respondents noted that of the Medicaid recipients who used inpatient hospital care, 92.2% of the nonhandicapped (31,626 ÷ 34,288) would have been fully served by 14 days of coverage, whereas only 72.6% of the handicapped (12,235 ÷ 16,852) would have been fully served. Thus 27.4% of the handicapped users of this service, as opposed to 7.8% of the nonhandicapped users, required some hospitalization for which they would not be reimbursed if the 14-day limit went into effect. On the basis of these statistics respondents argued that the 14-day limit would have a disparate impact on the handicapped, and that they had therefore shown a prima facie violation of Section 504.

The district court rejected this argument. It held (Pet. App. A34-A35) that the proportionately greater hospital use by handicapped Medicaid eligibles in fiscal year 1979-1980 was not necessarily attributable to their handicaps, and that the 1979-1980 statistics therefore showed little about likely future hospital use.[6] In any event, the court

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[4] The pertinent eligibility criteria for Medicaid benefits are described at page 6, *infra*. For further comment on the question of who are the "handicapped" see note 13, *infra*.

[5] Thus 18.6% of all handicapped Medicaid recipients (16,852 ÷ 90,668) used inpatient hospital care, while 13.6% of nonhandicapped recipients (34,288 ÷ 251,292) used this service.

[6] The court said (Pet. App. A34 n.6):

> For example, there was no attempt to show what percentage of handicapped users required inpatient hospital treatment as

held that the disparity shown by respondents "[did] not amount to discrimination" under Section 504 (Pet. App. A40).

On appeal the Sixth Circuit vacated and remanded for further proceedings, holding that respondents had shown a disparate impact, and therefore established a prima facie case (Pet. App. A1-A19). Citing medical testimony describing the inpatient hospitalization patterns of patients with various handicaps,[7] the court found to be clearly erroneous the district court's finding that the disparity demonstrated for 1979-1980 might not continue in later years (Pet. App. A10-A12).[8] The court further held that that disparity sufficed to establish a prima facie case, stating (Pet. App. A9-A10):

> [T]he district court erred by confusing the prima facie case with a decision on the ultimate outcome. * * * The establishment of disparate impact is not determinative of whether the defendant is guilty of discrimination. It merely requires the defendant to rebut the inference of discriminatory action. * * * [T]he showing of disparate impact proved a prima facie case and required the state to explain its choice.

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a result of their handicapping condition. It seems likely that some handicaps, such as blindness, would rarely require hospitalization, while others, such as mental illness, might well require frequent hospitalization. Without some such evidence, the court is left to speculate on what extent the existence of handicaps in the broad sense of § 504 affects the statistical disparity shown for the study year.

The court also pointed out (*ibid.*) that even in 1979-1980 only 5% of all handicapped Medicaid eligibles (27.4% × 18.6%) needed more than 14 days of inpatient hospital care. The corresponding figure for nonhandicapped Medicaid eligibles was 1% (7.8% × 13.6%).

[7] The State also admitted in its appellate brief that "the handicapped population of Medicaid recipients would suffer proportionately more from the reduction in hospital benefits than the nonhandicapped Medicaid recipients" (see Pet. App. A11 n.7).

[8] The court "disagree[d]" (Pet. App. A10) with the district court's finding that the evidence did not indicate the extent to which the existence of handicaps affects the statistical disparity.

The court went on to consider the justification offered by the State for its proposed reduction in inpatient hospital coverage (Pet. App. A12-A16). The court found that the State "was justified in attempting to reduce its Medicaid expenses" (Pet. App. A13). It noted, however, that respondents—in addition to proving a prima facie case of disparate impact—had presented an alternative plan that might have affected the handicapped less while still reducing the State's expenses.[9] The court held that under these circumstances the State must rebut the prima facie case either by "demonstrat[ing] that the alternative method * * * will not accomplish the State's objective of cost-saving," [10] or by "coming forward with some substantial justification for the adoption of the plan with the greater discriminatory impact" (Pet. App. A16).[11]

2.a. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) provides:

> No otherwise qualified handicapped individual * * * shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance * * *.

A "handicapped individual" is defined as "any person who (i) has a physical or mental impairment which sub-

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[9] As the district court indicated (Pet. App. A36 n.7), respondents' plan would have limited inpatient hospital coverage on a per-stay basis rather than a per-year basis. The court of appeals' characterization of the plan as "limiting the total number of visits per annum rather than the number of days" (Pet. App. A13) is incorrect. Respondents proposed that a fixed number of days be allowed for each type of hospital stay (*e.g.*, appendectomy, coronary bypass surgery), based on a fixed percentage (whatever was needed to keep the total cost within the State's budget) of the average number of days needed for stays of that nature. See Br. in Opp. 3 n.1; J.A. 59-61, 98-107, 120-121; C.A. App. 320-329.

[10] We assume that demonstrating that the alternative method does not really have a lesser disparate impact on the handicapped would also suffice to rebut the prima facie case.

[11] Judge Merritt dissented (Pet. App. A20-A26).

stantially limits one or more of such person's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment" (29 U.S.C. 706(7)(B)). HHS regulations implementing Section 504 define "major life activities" as "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working" (45 C.F.R. 84.3(j)(2)(ii)).

b. Title XIX of the Social Security Act (see 42 U.S.C. (Supp. V) 1396a(a)(10)) ties eligibility for Medicaid benefits to eligibility for either Supplemental Security Income (SSI) (42 U.S.C. 1381 *et seq.*) or Aid to Families with Dependent Children (AFDC) (42 U.S.C. (& Supp. V) 601 *et seq.*). It is thus essentially limited to five categories of individuals: (1) the blind; (2) the disabled; (3) the aged (65 or older); (4) dependent children (generally under age 18) deprived of parental support; and (5) caretaker-relatives of such children.[12] Eligibility is also limited by financial and other considerations, but no one, regardless of income, is eligible for Medicaid unless he falls into one of these five categories.

A person is "disabled" for purposes of SSI and Medicaid eligibility "if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months" (42 U.S.C. 1382c(a)(3)(A)).

INTRODUCTION AND SUMMARY OF ARGUMENT

The question we address in this brief is whether Tennessee's 14-day limit on Medicaid coverage for inpatient hospital care has a disparate impact on the handicapped[13]

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[12] The first three categories are SSI eligibles; the last two are AFDC eligibles.

[13] As we mentioned above, throughout this litigation the term "handicapped Medicaid eligibles" has been used to describe the blind and disabled, and "nonhandicapped Medicaid eligibles" to describe all others. But as the statutory definitions show, while the blind and the disabled *are* "handicapped" for purposes of Section

so as to constitute a prima facie violation of Section 504 of the Rehabilitation Act.

The petition presents as a separate antecedent question whether "a 'disparate impact' or 'effects' test [is] appropriate to determine a violation of § 504 of the Rehabilitation Act of 1973 and regulations issued thereunder" (Pet. i). This issue was not briefed, argued, or decided in either the district court or the court of appeals. Our brief in this case proceeds on the assumption that a showing of "disparate effects" could, in a proper case, constitute a prima facie violation of Section 504—either because Sec-

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504, it does not follow that persons who qualify for Medicaid on some other basis are *not*. The class of "handicapped" persons protected by Section 504 is in fact much broader than the class of "disabled" persons eligible for Medicaid benefits. Section 504 protects people fully capable of engaging in "substantial gainful activity" (42 U.S.C. 1382c(a)(3)(A)), who have either (i) a physical or mental impairment (or a *record* of such an impairment) which is *regarded* as limiting their ability to work, or (ii) a physical or mental impairment (or a *record* of such an impairment) which substantially limits (or is *regarded* as limiting) some *other* "major life activit[y]." 29 U.S.C. 706(7)(B). Thus, for example, dyslexic and hearing-impaired AFDC recipients would be "handicapped" under Section 504, but would have been included in the class of "nonhandicapped Medicaid eligibles" in the statistics used here. Had they instead been included among the "handicapped Medicaid eligibles," the proof might have been significantly different. If their handicaps do not require much hospital care, the percentage of the handicapped requiring more than 14 days would have been lower than 27.4% (since the denominator would have been larger), and the percentage of the nonhandicapped would have been higher than 7.8% (since the denominator would have been correspondingly smaller).

As a result, we think that the court of appeals' decision (quite apart from any legal error) rests on an erroneous factual premise—that it is "the handicapped" *as defined in the Rehabilitation Act* who are disproportionately affected by Tennessee's plan. If the Court should disagree with our principal contention (pages 10-30, *infra*), it may nonetheless wish to consider vacating the judgment below and remanding to the court of appeals with instructions to remand to the district court for further findings of fact that are consistent with the definition of "handicapped individual" set forth in 29 U.S.C. 706(7)(B).

tion 504 itself may encompass "disparate effects," [14] or because the numerous agency regulations implementing Section 504—which prohibit recipients from using criteria that have the "purpose *or* effect" of discriminating against the handicapped [15]—may constitute a valid means of implementing the open-ended statutory directive. See *Guardians Association* v. *Civil Service Commission*, No. 81-431 (July 1, 1983).

However, we do not think that the Court needs to pass on the validity of either of these assumptions, or to revisit the question that so troubled the Court in *Guardians* under the parallel provisions of Title VI—the role of purpose and effect in interpreting the statute and the regulations. As we demonstrate below, Tennessee's plan does not have a disparate impact on the handicapped even if one assumes that an "effects" test is proper. A finding of disparate impact depends on a showing that the handicapped are affected unequally with respect to some relevant good or benefit. In this case Tennessee has provided the same good or benefit (hospital care up to 14 days) to all individuals eligible for Medicaid (pages 11-12, 16-21, *infra*).

Should the Court reject our principal contention, and conclude that the facts here can constitute a showing of disparate impact, two questions would still remain to be decided. The first is whether such a showing is legally sufficient to establish a prima facie case under Section 504 and its regulations. The second is whether, if it is, the State here successfully rebutted the respondents' showing.[16] We suggest that the appropriate disposition of both of these questions would be to remand them for determination in the first instance by the lower courts, where they have not yet been considered.

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[14] This Court has not considered whether the differences in statutory language and legislative history between Title VI and Section 504 would require a different result here than the Court reached in *Guardians Association* v. *Civil Service Commission*, No. 81-431 (July 1, 1983), on this question.

[15] See page 14, *infra*.

[16] See note 17, *infra*.

We turn then to the court of appeals' conclusion that the State's proposed 14-day limit on Medicaid coverage for inpatient hospital care would have a disparate impact on the handicapped, and that respondents had therefore made out a prima facie case under Section 504. This conclusion is erroneous.

A. Respondents' showing of "disparate impact" is legally insufficient because the State plan offers the same benefit to all Medicaid eligibles, handicapped and non-handicapped alike. The court of appeals' conclusion that the handicapped are affected "more harshly than others" (Pet. App. A8) rests on the assumption that the benefit Tennessee is conferring is not a fixed amount of health services, but the satisfaction of health needs. That assumption is incorrect.

Section 504 does not dictate what kind of benefit a recipient of federal funds must provide. It simply commands that the handicapped be allowed to share equally in the benefits of a federally assisted program, whatever those may be. What those benefits are is in the first instance determined by the federal fund recipient (here the State), which is the entity that has chosen to undertake the program or activity of distributing those benefits. That determination must, of course, be consistent with the federal funding statute (here the Medicaid Act) that subsidizes the recipient's program or activity. Here all the State has undertaken is to give Medicaid eligibles inpatient hospital services up to 14 days. Such a limitation on hospital care is fully consistent with the Medicaid Act, which defines "medical assistance" as "payment of part * * * of the cost of * * * care and services." 42 U.S.C. (Supp. V) 1396d(a). Indeed the Medicaid Act includes its own equality provision (one more specific than Section 504), which says only that "the medical assistance made available to any individual * * * shall not be less in *amount, duration, or scope* than the medical assistance made available to any other * * * individual." 42 U.S.C. (Supp. V) 1396a(a)(10) (emphasis added).

B. The court of appeals appears to have thought that Section 504, while leaving a recipient free to choose "the

goal of [its] program" (Pet. App. A12 n.8), requires funds to be allocated so that the handicapped and non-handicapped are equally successful in achieving that ultimate goal.

1. This suggestion dissolves all distinction between nondiscrimination and affirmative action. It may be that a greater percentage of the handicapped require more than 14 days of hospital care to achieve the ultimate goal of good health. But the same would be true if the State reverted to a 20-day limit. The only way to assure equality in reaching the goal of good health is to allocate more health care money per capita to the handicapped. Section 504—an antidiscrimination (rather than an affirmative action) statute—does not mandate such a redistributive subsidy. Indeed, such a redistribution may well have a disparate impact on other groups protected by other antidiscrimination laws.

2. An approach requiring equality of results is unsupported by the case law dealing with Section 504 and cognate statutes. In *Southeastern Community College* v. *Davis*, 442 U.S. 397 (1979), this Court made clear that discrimination against the handicapped should be measured in the context of the "program" as defined by the recipient of federal funds. It also held that "[t]he language and structure of the Rehabilitation Act of 1973 reflect a recognition by Congress of the distinction between the evenhanded treatment of qualified handicapped persons and affirmative efforts to overcome the disabilities caused by handicaps. * * * Section 504 does not refer at all to affirmative action." 442 U.S. at 410.

ARGUMENT

TENNESSEE'S 14-DAY LIMIT ON INPATIENT HOSPITAL CARE FOR ALL MEDICAID RECIPIENTS DOES NOT HAVE A DISPARATE IMPACT ON THE HANDICAPPED, AND SO IS CONSISTENT WITH SECTION 504 AND ITS IMPLEMENTING REGULATIONS

According to the court of appeals, respondents demonstrated that the State's proposed 14-day limit on Medicaid

coverage for inpatient hospital care would have a disparate impact on the handicapped, and therefore established a prima facie case under Section 504.[17] This conclusion is erroneous.

A. Tennessee's Plan Does Not Have A Disparate Impact Because The Relevant Benefit (Hospital Services) Is Provided Equally To Handicapped And Nonhandicapped Alike

The court of appeals held that Tennessee's plan was "a facially neutral policy which affected [the] protected group[] more harshly than others" (Pet. App. A8). But in one obvious way the State's plan affects everyone equally: all Medicaid recipients are entitled to 14 days of hospital care; none is entitled to more. The court's conclusion is meaningful only if one assumes that the rel-

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[17] Application of a disparate impact test, in cases where it is appropriate, typically involves three steps: (1) the plaintiff must establish that the challenged act or practice has a disproportionate adverse effect on a protected class; (2) the defendant must then demonstrate that the act or practice has a "manifest relationship" to a legitimate interest; (3) "[e]ven in such a case, * * * the plaintiff may prevail if he shows that the [defendant] was using the practice as a mere pretext for discrimination." *Connecticut* v. *Teal*, 457 U.S. 440, 447 (1982). See *Albemarle Paper Co.* v. *Moody*, 422 U.S. 405, 425 (1975) (quoting *Griggs* v. *Duke Power Co.*, 401 U.S. 424, 432 (1971)(Title VII). See also *NAACP* v. *Medical Center, Inc.*, 657 F.2d 1322, 1334-1335 (3d Cir. 1981) (en banc) (Title VI); *Bryan* v. *Koch*, 627 F.2d 612, 616-619 (2d Cir. 1980) (Title VI).

As we show below, this case is unlike the typical disparate impact case because the very existence of a disparity depends on how one defines the benefit that respondents are deprived of. If the benefit is properly defined as the provision of inpatient hospital services, then the handicapped are affected in precisely the same way as other Medicaid eligibles—under the State's proposal, everyone is subject to the identical 14-day limit on these services. To require the State to justify its 14-day limitation under these circumstances is to proceed to step (2) of the inquiry before the plaintiffs have made out a prima facie case under step (1). In the circumstances of this case it is thus part of the plaintiffs' initial burden to establish that the relevant benefit is something other than what the State maintains it is.

evant "good" or "benefit" [18] being distributed (and as to which a discriminatory effect is prohibited) is not the provision of health services, but the satisfaction of health needs.

How does one determine what is the relevant "good" or "benefit"? Our submission is that the answer cannot be derived from Section 504 itself. Section 504 was not intended to generate an independent substantive definition of what is the federally subsidized good or benefit as to which discrimination is prohibited. Rather, it is the recipient—here the State—that in the first instance must determine what benefit-distributing program or activity it wishes to undertake. (In this case we believe that Tennessee has undertaken a program of distributing, not satisfaction of health needs, but hospital care.) Of course, because the federal grant statute subsidizes the recipient's program or activity, the recipient's choice of benefits must be consistent with that federal law. (Here Tennessee's decision to distribute, as a benefit, up to 14 days of hospital care is fully consistent with the Medicaid Act.) The purpose of Section 504 is simply to assure that qualified handicapped individuals are given an equal opportunity to share in those benefits that the recipient has undertaken to distribute and the federal government has undertaken to subsidize.

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[18] Section 504 states that qualified handicapped individuals may not be "excluded from the participation in, be denied the *benefits* of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" (emphasis added). As this Court's decision in *North Haven Board of Education* v. *Bell*, 456 U.S. 512, 520 (1982), demonstrates, one may be "subjected to discrimination"—*e.g.*, in employment—even though he does not "directly benefit from federal grants, loans, or contracts." See also *Consolidated Rail Corp.* v. *Darrone*, No. 82-862 (Feb. 28, 1984). In this case, however, respondents' very claim is that the State has not given them their proper share of the good being handed out in a federally subsidized "benefit program." It is therefore appropriate to analyze the case as raising the question whether the relevant *benefit* is the provision of hospital services, or rather the satisfaction of health needs.

1. *Section 504 Does Not Dictate What Kind Of Benefit The State Must Provide*

Like the notion of equality itself,[19] Section 504 generates no self-contained or independent substantive rule of conduct. It states that "[n]o otherwise qualified handicapped individual * * * shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" (29 U.S.C. 794). Nothing in that language defines or even constrains the kind of "program or activity" a recipient may conduct, or what its "benefits" may be. It presumes that the program may be of "any" kind the federal government is willing to assist. Once the recipient has established a program and complied with the requirements for federal aid, however, Section 504 commands that the handicapped be given an equal opportunity to share in its benefits, whatever they may be.

Suppose Tennessee were to decide that it wished to give each of its citizens $100, to be spent on health care, and the federal government decided to contribute $70 per person for this program. Section 504 obviously requires that the handicapped, like everyone else, receive $100; but it would hardly be thought that the program was (prima facie) invalid under Section 504 because $100 may buy less "good health" for the handicapped than for the nonhandicapped. Similarly, if the State decides to offer specific health services, Section 504 simply insists that the handicapped have equal access to *those* services, not that those services produce equivalent *results* for the handicapped.

The Section 504 regulations (to which the court of appeals referred (Pet. App. A12 n.8)) are consistent with this understanding of the role of Section 504. 45 C.F.R. 84.4(b)(2) provides that

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[19] The term "equality" expresses a relation—the idea that some person or thing (X) is equal to another (Y) in some attribute (Z). What that attribute (Z) might be is determined not by the idea of equality but by some external system that makes it relevant.

> (2) For purposes of this part, aids, benefits, and services, to be equally effective, are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons, but must afford handicapped persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement, in the most integrated setting appropriate to the person's needs.[20]

Under this section, the handicapped must be given an "equal opportunity" to get "the same benefit" (whatever that may be) that the State offers to others. The explanatory appendix to the regulations illustrates what is meant by such an "equal opportunity" (45 C.F.R. Pt. 84 App. A, ¶ 6):

> For example, a welfare office that uses the telephone for communicating with its clients must provide alternative modes of communicating with its deaf clients.

The other provision referred to by the court of appeals (Pet. App. A8 & n.5, A12 n.8) was 45 C.F.R. 84.4(b)(4), which states:

> (4) A recipient may not, directly or through contractual or other arrangements, utilize criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, [or] (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect to handicapped persons * * *.

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[20] Section 84.4(b)(2) explains and qualifies 45 C.F.R. 84.4(b)(1)(iii), which states that

> (1) A recipient, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:
>
> * * * * *
>
> (iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others * * *.

Clause (i) speaks of discriminatory "effect," but like the statute, it says nothing about the kinds of benefits whose uneven distribution will have that result. Clause (ii) refers to the "*recipient's* program"; that program's "objectives" are assumed to have been defined by the recipient outside the framework of Section 504.

Thus Section 504 leaves a recipient of federal funds free to decide the kind of benefit it wishes to offer and the objectives of its program. The federal grant statute determines whether a program distributing that benefit is entitled to a federal subsidy. And Section 504 comes into play at the next step: whatever benefit *is* offered, and has been subsidized, must be made available to the handicapped on equal terms with the nonhandicapped. The explanatory appendix gives the following examples:

> Recipients are not required * * * to provide specialized services and aids to handicapped persons in health programs. If, for example, a college infirmary treats only simple disorders such as cuts, bruises, and colds, its obligation to handicapped persons is to treat such disorders for them.

45 C.F.R. Pt. 84 App. A, ¶ 33.

> One common misconception about the regulation [21] is that it would require specialized hospitals and other health care providers to treat all handicapped persons. The regulation makes no such requirement. Thus, a burn treatment center need not provide other types of medical treatment to handicapped persons unless it provides such medical services to nonhandicapped persons. It could not, however, refuse to treat the burns of a deaf person because of his or her deafness.

45 C.F.R. Pt. 84 App. A, ¶ 36. A third discusses the regulation (45 C.F.R. 84.53) forbidding discrimination in the treatment of drug and alcohol addicts:

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[21] The regulation referred to is 45 C.F.R. 84.52(a), which specifically addresses discrimination against the handicapped in the provision of health, welfare, and other social services.

> This provision does not mean that all hospitals and outpatient facilities must treat drug addiction and alcoholism. It simply means, for example, that a cancer clinic may not refuse to treat cancer patients simply because they are also alcoholics.

45 C.F.R. Pt. 84 App. A, ¶ 37.

In this case the court of appeals found it significant that Tennessee's plan, by limiting coverage to 14 days, would not "afford the best cure" (Pet. App. A12 n.8) for some sufferers of "asthma, emphysema, chronic bronchitis," and "'[d]egenerative diseases of neurology'" (*id.* at A11). But that is no different from saying that the State has not chosen to pay for treatment of drug addiction or alcoholism, or for major disorders in general, or for anything other than burn treatment. Section 504 does not require the State to treat those conditions at all. A fortiori it does not require the State to provide more than 14 days of hospital care for them, particularly when it does not do so for other conditions.[22]

2. *Tennessee Law And The Medicaid Act Contemplate That The Relevant Benefit (The Provision Of Health Services) May Be Subject To A Reasonable Annual Limit*

The court of appeals apparently believed that Tennessee law and the Medicaid Act do not contemplate a benefit program of health services subject to a flat annual maximum. It held that it (Pet. App. A12 n.8):

> would be too simplistic an analysis to hold that all the Medicaid program requires is a particular number of days in the hospital. Rather, it is likely that

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[22] Other cases dealing with claims like respondents' have understood this point. See, *e.g.*, *Doe* v. *Colautti*, 592 F.2d 704, 707-710 (3d Cir. 1979) (state may limit the number of days it will pay for hospitalization in a private mental institution, though it provides unlimited hospitalization for physical illness); *Doe* v. *Devine*, 545 F. Supp. 576, 585 (D.D.C. 1982), aff'd on other grounds, 703 F.2d 1319 (D.C. Cir. 1983) (reduction of inpatient mental health benefits below the levels for physical illness).

> the objective is to afford the best cure, therapy, or preventative treatment that the allotted funds can provide.[23] This is made clear by the Tennessee law defining medical assistance as the "payment of the cost of care, services and supplies necessary to prevent, diagnose, correct or cure conditions in the person." Tenn. Code Ann. § 14-23.103(2).

Nothing in Tennessee law, however, suggests that the State has chosen to distribute anything other than a limited amount of health services. On the contrary, Tennessee law specifically empowers "[t]he commissioner [of public health] * * * by rule and regulation [to] fix the maximum level of services as are deemed necessary to insure that an expenditure of state funds shall not exceed the amount provided for those purposes." Tenn. Code Ann. § 14-23-109 (1980). Pursuant to this provision, the commissioner had previously limited coverage to 20 days for all Medicaid recipients. By the reduction at issue in this case he proposed, pursuant to the same authority, to offer needed care up to 14 days—nothing more, nothing less.

The court of appeals also said that it "would be too simplistic * * * to hold that all the Medicaid program

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[23] The meaning of this is somewhat obscure. Obviously, if "the allotted funds" are limited, the State cannot pay for cures in all cases. And curing those who can be healed in 14 days—with substantial help (14 days of care) for those who cannot—is certainly one way of defining "the best cure * * * the allotted funds can provide." Another way of distributing funds might be that proposed by respondents: paying a percentage of each person's stay in the hospital, with no limit on the number of stays. That would not provide a cure in any case (since the percentage must be less than 100% if funds are limited), but would give the most seriously ill (people needing more than 14 days of care) the same percentage of their costs as the least seriously ill. The court of appeals seems to have envisioned a third possible scheme: an annual limit on the number of stays, but no limit on the number of days per stay (Pet. App. A13-A14). This would provide cures in some cases (patients who had not used up their allotted number of stays), but not in all. Whether those uncured would number more than 7279 (the number of people needing more than 14 days of care) is not apparent from the record.

requires is a particular number of days in the hospital" (Pet. App. A12 n.8). We disagree. Both Title XIX of the Social Security Act (42 U.S.C. (& Supp. V) 1396 *et seq.*) and the Medicaid regulations (42 C.F.R. Pt. 430 *et seq.*) envision precisely that kind of limitation.[24] Section 1901 of the Act provides for grants to states "[f]or the purpose of enabling each State, *as far as practicable under the conditions in such State*, to furnish * * * medical assistance" (42 U.S.C. 1396 (emphasis added)). "[M]edical assistance" is defined as "*payment of part* or all *of the cost* of * * * care and services" (42 U.S.C. (Supp. V) 1396d(a) (emphasis added)). Section 1902 of the Act requires state plans to "include *reasonable* standards * * * for determining * * * *the extent* of medical assistance under the plan" (42 U.S.C. 1396a(a)(17) (emphasis added)).

Tennessee's proposal is also consistent with the equality rule incorporated in Section 1902(a)(10) of the Medicaid Act. That section is far more specific than Section 504 about the kind of Medicaid benefits the blind and disabled are entitled to get on equal terms with others. It states (42 U.S.C. (Supp. V) 1396a(a)(10) (emphasis added)):

> (a) A State plan for medical assistance must—
>
> * * * * *
>
> (10) provide—
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> * * * * *
>
> (B) that the medical assistance made available to any individual described in clause (A)[25]—

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[24] We note that Section 504 regulations must "be consistent with achievement of the objectives of the statute authorizing the financial assistance." 42 U.S.C. 2000d-1; 29 U.S.C. 794a(a)(2).

[25] "[C]lause (A)" refers to

> all individuals receiving aid or assistance under any plan of the State approved under * * * part A [AFDC] or part E [Foster Care and Adoption Assistance] of subchapter IV of this chapter * * *, or with respect to whom supplemental security in-

> (i) shall not be less in *amount, duration, or scope* than the medical assistance made available to any other such individual * * *.

See also 42 C.F.R. 440.240. The court of appeals itself held, somewhat quixotically, that the State's proposal was in "the best interests of Tennessee Medicaid recipients" (Pet. App. A16), and consistent with Section 1902(a)(19) of the Act, 42 U.S.C. 1396a(a)(19).[26] Finally, the regulations implementing the Act also permit a state agency to "place appropriate limits on a service" (42 C.F.R. 440.230(d)), so long as the service provided is "sufficient in amount, duration, and scope to reasonably achieve its purpose" (*id.* § 440.230(b)).[27]

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come benefits are being paid under subchapter XVI [SSI] of this chapter * * *.

Respondents claim that Tennessee has discriminated against the blind and the disabled (a subclass of SSI recipients) by offering them medical assistance *equal* "in amount, duration, [and] scope" to that offered other Medicaid recipients (AFDC recipients and aged SSI recipients).

[26] That section provides that

> (a) A State plan for medical assistance must—
>
> * * * * *
>
> (19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients.

[27] The Medicaid Act specifically permits a number of other cost-cutting approaches whose effect on the blind and disabled would be more severe than Tennessee's proposal. One is the "Section 209(b) option," which would permit a state to cover fewer of the blind and disabled than are eligible for SSI. See *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 38-39 (1981); 42 U.S.C. 1396a(f). The Act also makes it possible for a state to drop the disabled entirely from the covered group of medically (as opopsed to categorically) needy. 42 U.S.C. (Supp. V) 1396c(a)(10)(C); H.R. Conf. Rep. 97-208, 97th Cong., 1st Sess. 970-971 (1981). (For a discussion of the distinction between the categorically and the medically needy, see *Schweiker* v. *Gray Panthers*, 453 U.S. at 37.)

Other courts have concluded that similar (and even shorter) annual limits on hospital care are consistent with the Medicaid Act. See, *e.g.*, *Charleston Memorial Hospital* v. *Conrad*, 693 F.2d 324, 329-330 (4th Cir. 1982) (inpatient hospital days limited to 12); *Virginia Hospital Ass'n* v. *Kenley*, 427 F. Supp. 781 (E.D. Va. 1977) (inpatient hospital days limited to 21); cf. *Curtis* v. *Taylor*, 625 F.2d 645, 653, modified, 648 F.2d 946 (5th Cir. 1980) (reduction in coverage of physician visits to three per month). Such limits are permissible, the courts have held, so long as the "state plan will meet the medical needs of 'most' eligible Medicaid recipients." *Charleston Memorial Hospital* v. *Conrad*, 693 F.2d at 330. Here the district court found that the state plan would fully serve 95% of even handicapped Medicaid eligibles (Pet. App. A34 n.6). For that reason the Health Care Financing Administration has approved Tennessee's 14-day limit.[28] Similar annual limits are currently in effect in nine other states.[29]

To conclude: whether respondents have shown a prima facie case of disparate impact depends on the nature of the benefit Tennessee has allegedly distributed in unequal fashion. Section 504, however, is not an independent source of law that defines what benefit a recipient of federal funds must offer. Instead, it directs that the handicapped be afforded an equal opportunity to share in whatever benefit a recipient's program, as subsidized by the federal grant statute, happens to provide. Here Tennessee law, in conformity with the Medicaid Act and its regulations, has chosen to offer a limited amount of health

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[28] We have reproduced at App., *infra*, 1a-4a, a copy of the August 25, 1981 Notice of Approval and Attachment 3.1.A.1. (The "Subject of Amendment" in the Notice (App., *infra*, 2a) includes an ellipsis. The full title of the subject is "Inpatient hospital services other than those provided in an institution for mental diseases or tuberculosis." We have appended at App., *infra*, 5a-9a, a September 26, 1983 Notice which makes this clear.)

[29] We have reproduced at App., *infra*, 10a, a list of those states and their annual limits. The source of this information is LaJolla Management Corporation, *Analysis of State Medicaid Program Characteristics, 1983*, at 47-48 (Dec. 1983).

services (not satisfaction of health needs) on equal terms to all individuals eligible for Medicaid. In the distribution of that benefit there is no disparate impact on the handicapped.

B. Section 504 Should Not Be Read As Requiring The State To Distribute Program Benefits In A Way That Produces Equality Of Results

One might attempt, even accepting all we have said thus far, to defend the court of appeals' decision on a more sophisticated level. The court did not, after all, say that the State had to take money allocated for hospital care and spend it for some unrelated benefit. Instead the court sought out the underlying purpose of hospital care —"good health" (Pet. App. A22)—and required that the handicapped be assured of the same success rate as the nonhandicapped in achieving that purpose (Pet. App. A12 n.8). Its assumption seems to have been that Section 504 leaves a recipient free to choose the purpose of its program, but requires that the available funds be allocated so as to create equality of results with respect to that ultimate or fundamental purpose.

We do not think that Section 504 can bear such a reading. Section 504 was designed simply to eliminate discrimination against the handicapped, not to require the creation of subsidy (or affirmative-action) programs which will produce equality of results for them. The court of appeals' approach has the effect of dissolving all distinctions between nondiscrimination on the one hand, and subsidy or affirmative action on the other. Section 504 should not be read to obliterate the commonly understood conceptual categories against which it was enacted and which serve to make meaningful its animating concerns. Further, the court of appeals' approach reads Section 504 as requiring the State to engage in a significant redistribution from the nonhandicapped to the handicapped, a result that should not be required in the absence of a clear indication of congressional intent. Finally, the court's approach, by requiring the State to

apportion Medicaid funds to achieve equal results for the handicapped and the nonhandicapped, may produce new inequalities affecting other protected groups. These consequences of the court's approach are not supported by the case law dealing with Section 504 and cognate statutes.

1. *The Court Of Appeals' Approach Obliterates The Distinction Between Nondiscrimination And Affirmative Action, Requires Unforeseen Subsidies, And Produces New Disparate Impacts Of Its Own*

a. Congress does not legislate in a vacuum. When it enacts statutes such as Section 504, which refer to concepts such as discrimination, it must be taken to refer to conceptual categories that have some commonly understood meaning. The fundamental problem with the court of appeals' approach is that it ascribes to Congress a reductionist intention to obliterate these conceptual meanings and to dissolve the distinctions that flow from them.

One common assumption—confirmed by the functioning of our markets—is that a person who offers the same goods and services at the same price to all customers is treating all customers equally (is not *discriminating* against any of them) even though the satisfaction that the same goods will create in individual customers may vary. If a hospital offers everyone health care at $ *X* per day, it is treating everyone equally, and there is no discrimination even if some people need care more than others. Society may then decide that people who are in greater need of hospital care should be provided with lower-priced (or free) care, but that is thought of as a question of subsidy, not a question of how to eliminate discrimination. In just the same way, once society has decided to subsidize a limited amount of hospital care for a group of people, it cannot be thought to *discriminate* if it leaves all of them subject to the identical limit (and thus subject to the market for their unmet needs), even though some may have greater needs than others.

If one accepts the court of appeals' hypothesis that the underlying purpose of Tennessee's plan is good health,

and that any benefit package giving the handicapped a lower success rate in achieving that result has a disparate impact, the real issue becomes not whether Tennessee can reduce its hospital coverage from 20 to 14 days, but whether it can impose *any* annual limit on coverage. The reason is that although the number of handicapped needing further hospitalization decreases with more coverage, the disproportion in "cures" between handicapped and nonhandicapped actually *increases* as the maximum stay period is lengthened (J.A. 182-183).[30]

It would of course be possible to avoid all such "disparate impacts" by providing 365 days of hospital coverage. Then everyone would be offered the same benefit, and the handicapped and nonhandicapped would have their needs met in equal fashion. Yet even the court of appeals agreed that "[t]he State * * * was justified in attempting to reduce its Medicaid expenses" (Pet. App. A13). The only other possible solution that satisfies the "purpose" identified by the court of appeals is to redistribute the funds available for hospital care by giving more per capita to the handicapped, so that equal percentages of the handicapped and nonhandicapped may achieve the goal of good health. This converts Section 504 from an antidiscrimination statute into an instrument of affirmative-action redistribution. No matter how wise or humane this may be as a matter of social policy, it would be unwarranted to read such a policy into the sparse and limited language of Section 504.

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[30] For example, while 3.5 times as many handicapped as nonhandicapped Medicaid-eligible hospital users (27.4% ÷ 7.8%) require more than 14 days of hospitalization, 4.02 times as many (16.9% ÷ 4.2%) require more than 19 days. We illustrate in App., *infra*, 11a, that this proposition is true for every increase in coverage from one to 19 days. Although there are no figures to show the relative rates of utilization for exactly 20 days, the parties stipulated that they did "not have any information that would indicate that patterns of patient utilization of twenty days coverage per year differ significantly from patterns of utilization of fifteen to nineteen (15-19) days of hospitalization per year" (J.A. 40). The figures given in App., *infra*, 11a, are taken from J.A. 182-183.

b. To read Section 504 as animated by the general underlying purpose of producing equality of results might have the untoward consequence of creating (or increasing) disparate impacts (so conceived) with respect to other groups, some themselves protected by antidiscrimination laws.

We start here with the fact that the handicapped as a class *already* receive proportionately more of the State's Medicaid assistance—including hospital care—than do the nonhandicapped as a class. A greater proportion of handicapped than nonhandicapped persons is eligible for Medicaid benefits in the first place, because persons between 21 and 65 (with no dependent children) cannot qualify for Medicaid coverage (regardless of income) unless they are either blind or disabled. Further, of those eligible for Medicaid, a greater proportion of the handicapped than of the nonhandicapped receives inpatient hospital care. See note 5, *supra*. Finally, of those who receive inpatient hospital care, a greater proportion of handicapped than of nonhandicapped persons uses the full 14 days of care offered under the State's plan. See page 3, *supra*, and App., *infra*, 11a.

The court of appeals' approach would require increasing these disproportions. But if the State must pay still more money per capita annually for hospital care for the blind and disabled, it will necessarily pay less for AFDC recipients. See page 6, *supra*. And if in Tennessee, as in Texas, "the proportion of AFDC recipients who are black or Mexican-American is higher than the proportion of the * * * blind, or disabled welfare recipients who fall within these minority groups" (*Jefferson* v. *Hackney*, 406 U.S. 535, 538 (1972)), respondents' proposal might be considered to have a "disparate impact" on those protected by Title VI.

Making results rather than benefits the focus for identifying disparate impact would have similar consequences outside the area of health care. Consider, for example, the question of federal financial aid to elementary and secondary schools. See, *e.g.*, 20 U.S.C. 2701 *et seq.*;

20 U.S.C. 3801 *et seq.* One might say that the underlying purpose of such school programs is not the provision of educational services, but the successful achievement of learning—measured perhaps by SAT scores. One could then claim that such a program had a disparate impact on the mentally handicapped if funds were not so allocated as to bring their SAT scores into parity with those of the nonhandicapped.[31] But a redistribution of this sort—what in common understanding would be regarded as affirmative action in favor of the handicapped—may very well have a disparate impact on disadvantaged (but nonhandicapped) minorities protected by Title VI.

Indeed, even a system of direct cash grants in equal amounts to all individuals below a certain income level could be suspect under Section 504, provided one defined the purpose of the grants in sufficiently general result-oriented terms—to promote health or learning. And since the class protected by Section 504 is not necessarily congruent with the classes protected by Titles VI and IX, a redistribution of funds to help the handicapped better achieve the program's "purpose" would often create new disparate impacts of its own.[32]

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[31] The suggestion is not fanciful. One might sensibly object that the goal of equal SAT scores is naturally impossible for some children to reach, and that Section 504 does not require pointless expenditures. But in the same way the goal of good health ("the best cure" (Pet. App. A12 n.8)) is unattainable for some of the physically handicapped. Yet what the court of appeals' decision requires is that the handicapped as a class make the same progress toward that goal (have their medical needs met at the same rate) as the nonhandicapped as a class.

[32] As even the court of appeals acknowledged (Pet. App. A13), the State is entitled to "a great deal of latitude in structuring the services it provides to its citizens." See also *Beal* v. *Doe*, 432 U.S. 438, 444 (1977) (the Medicaid Act "confers broad discretion on the States to adopt standards for determining the extent of medical assistance"); *Jefferson* v. *Hackney*, 406 U.S. 535 (1972). "Even a completely neutral practice will inevitably have *some* disproportionate impact on one group or another. * * * [T]his Court has never held[] that discrimination must always be inferred from such consequences." *Los Angeles Dep't of Water & Power* v. *Manhart*, 435 U.S. 702, 711 n.20 (1978) (emphasis in original).

2. *The Cases Do Not Support The Conclusion That Inequalities In Result Automatically Constitute A Disparate Impact*

The cases decided by this Court and other courts under Section 504 do not support the approach taken by the court of appeals. In *Southeastern Community College* v. *Davis*, 442 U.S. 397 (1979), the issue was not whether the respondent got equal "benefits" from a federally assisted nursing program, but whether she was "qualified" to "participat[e] in" the program at all (29 U.S.C. 794). In answering that question, however, this Court assumed that it should measure discrimination in the context of the program as the recipient of federal assistance defined it[33] (442 U.S. at 413 n.12):

> Southeastern's program, structured to train persons who will be able to perform all normal roles of a registered nurse, represents a legitimate academic policy, and is accepted by the State.

To the argument that the respondent could benefit from (and perhaps even be licensed after completing) a suitably modified program, the Court responded (442 U.S. at 410):

> The language and structure of the Rehabilitation Act of 1973 reflect a recognition by Congress of the distinction between the evenhanded treatment of qualified handicapped persons and affirmative efforts to overcome the disabilities caused by handicaps. * * * * * * Section 504 does not refer at all to affirmative action. * * * Congress understood accommodation of the needs of handicapped individuals may require affirmative action and knew how to provide for it in those instances where it wished to do so.

In the cases relied upon by the court of appeals (Pet. App. A7-A10), where a disparate impact was found, the very benefit offered by the recipient reached the protected

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[33] See also *Timms* v. *Metropolitan School District of Wabash County*, 722 F.2d 1310, 1318 (7th Cir. 1983) ("[S]ection 504 forbids exclusion from programs rather than prescribing the programs' content.").

group in disproportionately small numbers.[34] Those cases therefore involved issues like that presented by architectural and transportation barriers. When a recipient of federal education aid provides a classroom or a library with no access ramp, it offers a benefit that—unlike Tennessee's hospital care—does not reach relatively equal numbers of the handicapped and nonhandicapped. The same is true when the recipient constructs a public transportation system with federal money, but designs it in a way that bars use by the handicapped.[35]

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[34] In *NAACP* v. *Medical Center, Inc.*, 657 F.2d 1322 (3d Cir. 1981) (en banc), the claim was that the recipient, by relocating a hospital, had made it more difficult for the handicapped and minorities to get to the facility. The court assumed, "without deciding, that the plaintiff [had] presented a prima facie case" under Title VI, and went on to hold that the recipient had adequately justified whatever burden it imposed on the protected group. 657 F.2d at 1324, 1333-1337. In *Bryan* v. *Koch*, 627 F.2d 612, 616-617 (2d Cir. 1980), the claim was that New York City, by offering hospital care only outside central Harlem, would fail to serve the black and hispanic patients who lived there. The court concluded that the plaintiffs had made a prima facie showing of disparate impact under Title VI, but that the City had adequately justified its decision. 627 F.2d at 616-620.

[35] See, *e.g.*, *Dopico* v. *Goldschmidt*, 687 F.2d 644 (2d Cir. 1982); but cf. *American Public Transit Ass'n* v. *Lewis*, 655 F.2d 1272, 1278 (D.C. Cir. 1981).

In *Georgia Association of Retarded Citizens* v. *McDaniel*, 716 F.2d 1565 (11th Cir. 1983) (*GARC*), a class of mentally retarded children raised claims under both Section 504 and the Education of the Handicapped Act, 20 U.S.C. 1401 *et seq.* (EHA), challenging the defendants' policy of refusing to consider providing education in excess of the traditional 180-day school year to handicapped children. Although the court did not analyze the plaintiffs' Section 504 claim in terms of "disparate impact," they alleged, in essence, that the 180-day limitation—although applied across the board to all school children—had a disparate impact on the severely and profoundly mentally retarded, who regressed as a result of the three-month summer break in their training. Such children, the plaintiffs argued, were therefore not provided an equal opportunity to benefit from their educational programs. The Eleventh Circuit sustained this claim.

We argued in the court of appeals (716 F.2d at 1580 n.15), and continue to believe, that the Section 504 holding in *GARC* is inconsistent with this Court's decision in *Southeastern Community Col-*

The point can perhaps best be illustrated by Aesop's fable about the fox and the stork. Section 504 is violated if a recipient offers the fox and the stork an equal amount of milk in a container only the stork can drink from. *Griggs* v. *Duke Power Co.*, 401 U.S. 424, 431 (1971). But if an equal amount of milk is offered in a container accessible to both, there is no discrimination under Section 504 even though the fox, in order to be healthy, needs more milk than the stork.

This Court has twice considered the issue of disparate impact under Title VI. In *Guardians Association*, *supra*, the use of an unvalidated written examination and a seniority system for layoffs caused minority candidates to be hired later and laid off sooner, so that proportionately fewer blacks and Hispanics than whites enjoyed the benefits of employment in a federally funded program. The case thus fits comfortably into the category of situations where the very benefit being offered by a recipient of federal funds is less accessible to the protected group than to others.

In *Lau* v. *Nichols*, 414 U.S. 563 (1974), the Court found that the use of English as the sole language for instruction had the effect of denying non-English-speaking Chinese children the benefits of public education (414

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lege v. *Davis*, 442 U.S. 397 (1979). *GARC* is in any event different from this case in one critical respect. The federal funds involved there included monies provided under the EHA for the purpose of providing each handicapped child with a "free appropriate public education" (20 U.S.C. 1412(1)), a purpose that requires consideration of the "unique needs" of each such child. 20 U.S.C. 1401(16) and (18). And as we pointed out above (pages 12, 18-21, *supra*), although Section 504 does not dictate the kinds of benefits a recipient may offer, such obligations may be imposed by the federal funding statute itself and the funding agency's regulations. For that reason the Section 504 regulations governing public education programs receiving aid from the Department of Education incorporate requirements similar to those imposed by the EHA. See 34 C.F.R. 104.33(a) ("free appropriate public education"), 104.33(b)(1) ("appropriate" education is one "designed to meet individual educational needs"). The Section 504 regulations governing recipients of HHS funds for health, welfare, and other social services, by contrast, contain no such requirement that individual needs be considered. 45 C.F.R. Pt. 84, Subpt. F.

U.S. at 568). The Court concluded that the federally funded program or activity was the provision of educational services, and that access to these services was completely cut off to those who were "handicapped" by their failure to speak English. The case thus is clearly analogous to ones where the handicapped are barred from access to a library or school by physical barriers; it nowhere suggests that it is discrimination not to allocate educational services in such a way as to produce equal achievement in learning.[36]

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[36] One can conceive of the benefit being distributed in *Lau* as "instruction-given-in-English" and then assert that Chinese-speaking students were offered that benefit like everyone else. In the same way, one can argue that a rampless library is offering, as a service, "books-in-a-building-without-ramps," and that *that* service is available equally to all; similarly, the fox and the stork do have equal access to the benefit of "milk-in-a-long-necked-container" if that is how one chooses to define the benefit.

The point illustrates that reductionist extensions can be made with equal logic in both directions. Antidiscrimination legislation can obviously be emptied of meaning if every discriminatory policy is "collapsed" into one's definition of what is the relevant benefit. But as the Court assumed in *Davis*, 442 U.S. at 410-411, Congress in Section 504 was legislating against a background in which there is some meaningful commonsense distinction between discrimination on the one hand and affirmative action on the other. To maintain that distinction, some generally understood distinction between what constitutes milk and what constitutes a container must be maintained. It is our submission that, in this case, the "milk" is the provision of inpatient hospital services, not "good health." The handicapped may not be discriminated against with respect to or barred from access to *that* service.

There is an additional difficulty with any suggestion that *Lau* controls this case. The Court there, in defining the school district's obligations, relied primarily on guidelines issued by the funding agency (HEW), which required federally assisted school districts "'to rectify * * * language deficienc[ies] in order to open' the instruction to students who had 'linguistic deficiencies'" (414 U.S. at 567, quoting 35 Fed. Reg. 11595 (1970)). And it is as true under Title VI as it is under Section 504 that "[i]dentification of those instances where a refusal to accommodate the needs of [the protected class] amounts to discrimination against [it] continues to be an important responsibility of HEW." *Southeastern Community College* v. *Davis*, 442 U.S. at 413. As we have already made clear, the concerned agency has found no such problem here.

The claim made by respondents here is not like the claims adjudicated in *Guardians* and *Lau*. Respondents do not contend that they, like employees hired late and dismissed early, receive a proportionately smaller share of the State's program benefits. Nor do they claim that 14 days of care would (like English instruction to Chinese speakers; or like a library without ramps for one in a wheelchair) be wholly ineffective for them. They argue instead that the handicapped, because of their relatively greater medical needs, will not achieve equality of results (in terms of good health) if hospitalization is limited to a maximum of 14 days for all. The solution they propose is an allocation of funds that will give the handicapped (per capita) more than the nonhandicapped —indeed, more than the unequal division the State already provides. This is the very kind of affirmative action that *Davis* held Section 504 does not require.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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MAY 1984

APPENDIX A

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: Health Care Financing Administration

Transmittal Number

AT-81-9

State

Tennessee

Program Identification

Title III

TO: Regional Administrator
Health Care Financing Administration
Department of Health and Human Services

Proposed Effective Date

Item #1. (a)—September 1, 1981

Item #1. (b)—July 1, 1981

Type of Plan Material (Check One)

☐ New State Plan

☒ Amendment to be Considered as New Plan

☐ Amendment

Complete Next 4 Blocks if This is an Amendment
(Separate transmittal for each amendment)

Federal Regulation Citation

42 CFR 440.10

Number of the Plan Section or Attachment

Attachment 3.1.A.1, Page 1

Amend item #1. (a) and (b)

Number of the Superseded Plan Section or Atachment

Attachment 3.1.A.1, Page 1

item #1

Subject of Amendment

Limitation on Amount, Duration and Scope of Medical Care and Services Provided—Inpatient Hospital . . . . tuberculosis.

Governor's Review (Check One)

☒ Governor's Office Reported No Comment

☐ Comments Of Governor's Office Enclosed

☐ No Reply Received Within 45 Days Of Submittal

☐ Other, As Specified:

Signature of State Agency Official

Typed Name:

Eugene W. Towinkle, M.D.

Title:

Commissioner

Date:

July 7, 1981

Return To:

Anna D. Boswell
Medicaid Program Relations
283 Plus Park Blvd.
Nashville, Tennessee 37217

For Regional Office Use Only

Date Received 7/29/81

Date Approved 8/25/81

Plan Approved—One Copy Attached

Effective date of Approved Material

Item 1(a)—September 1, 1981

Item 1(b)—July 1, 1981

Signature of Regional Official

/s/ Richard L. Morris

Typed Name:

Richard L. Morris

Title:

Associate Regional Administrator
Division of Program Operations

Remarks:

Attachment 3.1.A.1
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State

Tennessee

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

1. Inpatient hospital . . . tuberculosis
   (a) Limited to 14 days per fiscal year, effective September 1, 1981.
   (b) Friday or Saturday admissions limited to emergencies or surgery the same or next day.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: Health Care Financing Administration

TO: Regional Administrator
Health Care Financing Administration
Department of Health and Human Services

Transmittal Number

AT-83-10

State

Tennessee

Program Identification

Title XIX

Proposed Effective Date

September 1, 1983

Type of Plan Material (Check One)

☐ New State Plan

☒ Amendment To Be Considered As New Plan

☐ Amendment

Complete Next 4 Blocks if This is an Amendment
(Separate transmittal for each amendment)

Federal Regulation Citation

42 CFR 440.10, 42 CFR 440.40

Number of the Plan Section or Attachment

Attachment 3.1.B.1; Item 1

Attachment 3.1.A.1; Item 1

Attachment 3.1.A.1; Item 4.b.

Attachment 3.1.B.1; Item 4.b.

Number of the Superseded Plan Section or Attachment

Attachment 3.1.B.1; Item 1

Attachment 3.1.A.1; Item 1

Attachment 3.1.A.1; Item 4.b.

Attachment 3.1.B.1; Item 4.b.

Subject of Amendment

Inpatient Hospital Services Other Than Those Provided in an Institution for Mental Diseases or Tuberculosis Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age . . .

Governor's Review (Check One)

☒ Governor's Office Reported No Comment

☐ Comments Of Governor's Office Enclosed

☐ No Reply Received Within 45 Days Of Submittal

☐ Other, As Specified:

Signature of State Agency Official

/s/ James E. Word

Typed Name:

James E. Word

Title:

Commissioner

Date:

September 20, 1983

Return To:

Sheron B. Doss
Medicaid Auxiliary Unit
283 Plus Park Blvd.
Nashville, Tennessee 37217

For Regional Office Use Only

Date Received 9/22/83

Date Approved 9/26/83

Plan Approved—One Copy Attached

Effective Date of Approved Material 9/1/83

Signature of Regional Official

/s/ Richard L. Morris

Typed Name:

Richard L. Morris

Title:

Associate Regional Administrator, Reg. IV

Remarks:

Attachment 3.1.A.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State

Tennessee

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

1. Inpatient Hospital . . . . tuberculosis

(a) Limited to 14 days per fiscal year with the following exceptions:

(1) Infants with a birth weight of 3000 grams or less may receive up to twenty (20) days at the time of birth if identified as eligible for EPSDT Services and are in a recognized Neonatal Intensive Care Unit. Future hospital services for such infants will be on the same basis as other recipients.

(2) Individuals may also receive up to twenty (20) days if they are eligible for EPSDT services and the Department determines, after consultation with qualified experts, that the following conditions are met:

(i) the individual's condition is surgically correctable, was present at birth and is the result of faulty embryogenesis; and

(ii) the proposed procedure is medically necessary and efficacious; and

(iii) the proposed procedure is expected to prolong life expectancy or improve the quality of life.

(b) Friday or Saturday admissions limited to emergencies or surgery the same or next day.

September 26, 1983

Refer to:
DPO/SCOB/0M

Mr. James E. Word, Commissioner
Department of Health and Environment
344 Cordell Hull Building
Nashville, Tennessee 37219

Attn: Sheron Doss

Re: Tennessee Title XIX Plan Transmittal 83-10

Dear Commissioner Word:

We have completed our review of the above referenced plan amendment. We are pleased to inform you that this amendment to your Title XIX State Plan has been approved as submitted.

Sincerely,

Richard L. Morris
Associate Regional Administrator
Division of Program Operations

HCFA:DPO:SCOB:JMcClain:mh:9/27/83

APPENDIX B

Besides Tennessee, nine states limit the number of days of Medicaid coverage for inpatient hospital services per year.

State	Days Per Year
Florida	45
Idaho	40
Maine	30
Mississippi	30
Georgia	25
West Virginia	20
Alabama	15
Oregon	14
South Carolina	12

Six other states limit the number of reimbursable days per admission, per spell of illness, or per benefit period.

State	Reimbursable Days
South Dakota	60 days/benefit period
Ohio	30 days/spell of illness
Texas	30 days/spell of illness
Maryland	20 days/spell of illness
Kentucky	14 days/admission
Oklahoma	10 days/admission (with minimum of 20 days between discharge and readmission)

APPENDIX C

Comparison of handicapped (H) and nonhandicapped (NH) Medicaid-eligible hospital users requiring more inpatient hospital care than would be provided by ceilings of under 20 days per year on Medicaid coverage

Ceiling	Nonhandicapped (NH) (Total: 34,288)		Handicapped (H) (Total: 16,852)		% H ÷ % NH
	Number	Percent	Number	Percent	
1	30,711	89.6	15,907	94.4	1.05
2	23,097	67.4	14,552	86.4	1.28
3	17,310	50.5	13,243	78.6	1.56
4	13,838	40.4	11,987	71.1	1.76
5	11,195	32.6	10,858	64.4	1.98
6	9,095	26.5	9,820	58.3	2.20
7	7,497	21.9	8,827	52.4	2.39
8	6,315	18.4	7,974	47.3	2.57
9	5,375	15.7	7,301	43.3	2.76
10	4,623	13.5	6,629	39.3	2.91
11	4,000	11.7	6,077	36.1	3.09
12	3,474	10.1	5,584	33.1	3.28
13	3,045	8.9	5,088	30.2	3.39
14	2,662	7.8	4,617	27.4	3.51
15	2,370	6.9	4,224	25.1	3.64
16	2,072	6.0	3,835	22.8	3.80
17	1,821	5.3	3,481	20.7	3.91
18	1,615	4.7	3,153	18.7	3.98
19	1,429	4.2	2,844	16.9	4.02

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CLERK

No. 83-727

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1983

LAMAR ALEXANDER, Governor of the State of Tennessee, et al.,

Petitioners,

vs.

HERSHEL CHOATE, et al.,

Respondents.

PETITION ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF OF AMICI CURIAE CENTER FOR INDEPENDENT LIVING--SAN GABRIEL/POMONA VALLEYS, DISABLED RIGHTS UNION, SOUTHEAST CENTER FOR INDEPENDENT LIVING

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*Counsel of Record

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No. 83-727

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October Term, 1983

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Petitioners,

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FOR THE SIXTH CIRCUIT

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No. 83-727

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1983

LAMAR ALEXANDER, Governor of the State of Tennessee, et al.,

Petitioners,

vs.

HERSHEL CHOATE, et al.,

Respondents.

BRIEF OF AMICI CURIAE CENTER FOR INDEPENDENT LIVING--SAN GABRIEL/POMONA VALLEYS, DISABLED RIGHTS UNION, SOUTHEAST CENTER FOR INDEPENDENT LIVING

INTEREST OF AMICI

The amici are three Southern California independent living centers which are disabled run and controlled nonprofit organizations. Written permissions from petitioners and respondents for amici participation have been filed with the court. The independent living cen-

ters work toward the realization of the right of persons with disabilities to develop to their potential, to live with dignity and as independently as possible, and to live and contribute in the mainstream of society. These independent living centers and their constituents include persons who are dependent on Medicaid (in California called Medi-Cal) for their health care and who are at risk of needing extended inpatient hospital coverage to preserve their lives and level of functioning. Many very severely disabled Californians are alive and living independently in their communities rather than in institutions because cutbacks in California's Medicaid program have preserved equal access on the basis of Medical necessity and have avoided a design which disparately impacts on an affected class defined in

terms of the nature and severity of their handicaps.[1] Amici fear the consequences of a holding that the grossly disparate impact of Tennessee's 14-day hospital limitation does not constitute discrimination on the basis of handicap and a violation of §504 of the Rehabilitation Act, 29 U.S.C. §794. Such a holding would put at risk the lives and independence of disabled SSI recipients by licensing Medicaid designs which disparately impact upon them on the basis of handicap.

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[1] Severely disabled Californians are more likely to be living in the community outside of institutions than is the case in other states. For instance, although California has only 10% of the United States' population, per HHS Health Care Financing Agency (HCFA), half this Country's population of respirator-dependent persons who are living in the community and who are also eligible for Medicare are living in California. A nondiscriminatory California Medicaid program is one of the reasons severely disabled Californians are better able to avoid than are severely disabled living elsewhere.

CENTER FOR INDEPENDENT LIVING--SAN GABRIEL/POMONA VALLEYS in West Covina works with persons with disabilities in the communities east of Los Angeles in the San Gabriel and Pomona Valleys;

DISABLED RIGHTS UNION in Ventura works with persons with disabilities in Ventura County to the north of Los Angeles;

SOUTHEAST CENTER FOR INDEPENDENT LIVING (SECIL) in Downey works with persons with disabilities in the Southeast portion of Los Angeles County which includes some twenty cities such as Downey, Compton, Bell, Bell Gardens, Southgate.

SUMMARY OF ARGUMENT

Section 504 of the Rehabilitation Act, 29 USC §794, protects otherwise qualified handicapped individuals from the injurious effects of practices and program designs even though the practice or design was not undertaken for the purpose of injuring handicapped persons. Challenged here is the design of Tennessee's Medicaid inpatient hospital services program which limites coverage of hospital days to 14 in any one fiscal year. Respondents/Plaintiffs and those they represent are all "Otherwise Qualified Handicapped Individuals" because they are entitled to Medicaid because they receive Supplemental Security Income (SSI) based on disability and because they have or will meet the state's medical necessity criteria for coverage of inpatient hospital services.

The 14-day limitation has the effect of denying otherwise qualified handicapped individuals Medicaid coverage of necessary hospital services solely because the nature and severity of their handicaps require more than 14 days in a fiscal year. Although the Medicaid statute when read together with §504 impose an obligation on the state to consider the foreseeable consequences on handicapped persons when designing a program, the state failed to do so. Plaintiff's statistics showed a gross disparity of 28 standard deviations between the adverse effect of the 14-day limitation on the handicapped as opposed to the nonhandicapped hospital user population. The grossness of the disparity is evidence that the adverse effect was by reason of handicap and gives rise to a presumption that the affected class was adversely impacted upon by reason of

their handicap. If unrebutted, the burden of persuasion shifts to the Petitioner/Defendant to show that the program design is justified--just as a justification burden would shift to a defendant if a campus library were designed so as to exclude mobility impaired students who were otherwise qualified handicapped individuals.

A R G U M E N T

I.

THE WELL SETTLED LAW DEVELOPED BY THIS COURT ON ELEMENTS OF PROOF AND BURDENS OF PERSUASION AND PRODUCTION AS APPLIED TO § 504 DICTATE AFFIRMANCE OF THE CIRCUIT COURT DECISION.

A plaintiff's proof burden is determinable by parsing the language of the statute itself -- "§504 [29 U.S.C. §794] sets forth its own criteria for scrutinizing claims under that statute." Southeastern Community College v. Davis,

442 U.S. 397, 403, 99 S.Ct. 2361, 2365 (1979). Section 504 states

> No otherwise qualified handicapped individual... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

A. "any program or activity receiving Federal financial assistance"

Applicability of § 504 and the court's jurisdiction was undisputed because of the substantial financial involvement in the state's Medicaid program.[2]

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[2] Jennings v. Alexander, 518 F.Supp. 877, 880 (M.D. Tenn. 1981).

B. "otherwise qualified handicapped individual"

There are two sub-elements here: first, whether the plaintiff is a member of the protected class, and second whether the plaintiff is "otherwise qualified".

1. "handicapped individuals"

The protected class is defined at § 7(7)(B) of the Rehabilitation Act, 29 U.S.C. § 706(7)(B). It is undisputed that plaintiffs herein -- and those they sought to represent -- are all protected class members.[3] Plaintiffs and those

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[3] Jennings v. Alexander, supra, 518 F.Supp. at 880. Plaintiffs and those they represent fall within the first clause of the definition of handicapped in § 7(6)(B) of the Rehabilitation Act, 29 U.S.C. § 706(7)(B), in that each "has

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they sought to represent were disabled SSI recipients, a class that is bright-line defined in terms of the nature and severity of their disability.[4]

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a physical or mental impairment which substantially limits one or more of such person's major life activities...." While the first and second clause ("a record of such an impairment") cover persons who may be objectively defined as being within the protected class, the third clause ("regarded as having such an impairment") would cover only those persons who are defined as handicapped by a program's adverse action.

[4]All § 504 cases addressing systemic problems have involved affected classes defined in terms of the nature and severity of their disabilities. For instance, a case involving lack of ramp access to a school library involves discrimination against a class defined in terms of the nature and severity of its members handicap: persons whose disability involves a mobility impairment which is so severe as to prevent use of steps. The lack of stairs would disparately impact upon an affected class defined in terms of the nature and severity of its members'

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2. "otherwise qualified"

This element is satisfied by showing that a plaintiff "meets the essential eligibility requirements for the receipt of" Medicaid inpatient hospital services. 45 C.F.R. § 84.4(k)(4) (1983).

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handicapping conditions. The affected class in New Mexico Association for Retarded Citizens v. State of New Mexico, 678 F.2d 847 (10th Cir. 1982) were those otherwise qualified handicapped children who, because of their disability limitations, were unable to obtain system benefits realized by the non-handicapped -- again a class defined in terms of the nature and severity of its members' handicaps.

Plaintiffs and those they sought to represent[5] meet the essential eligibility requirements of the Medicaid inpatient hospital services program by virtue of their SSI status and by virtue of their demonstrated need for such inpatient services under the State Medicaid program criteria. Plaintiffs' otherwise qualified status also bright line defines the class they seek to represent. The affected class -- those otherwise qualified handicapped individuals who have or in the future will

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[5]Brief of Amicus Equal Employment Advisory Council (EEAC), discussions about the heterogeneity of the class protected by § 504 and arguments about why adverse impact statistics can never be used in a § 504 case overlooks the "otherwise qualified handicapped individual" step in the proof process. In most employment cases -- the type of cases the EEAC focuses on in its arguments -- the dispute is whether or not an applicant is "otherwise qualified." Adverse impact statistics simply do not come into play in such a case.

require more than 14 days of inpatient services by reason of their handicap -- is also bright-line defined.[6]

C. "solely by reason of his handicap"

Plaintiff is required to show a nexus between the adverse action and plaintiff's handicap or status as a person with a handicap. The "by reason of" language is comparable to the "because of" language in §703 of Title VII of the civil rights act of 1964, 42 U.S.C.

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[6] In Title VI national origin discrimination cases affected classes have been defined much more restrictively than suggested by the designation "national origin" -- as the non-English-Speaking Chinese pupils who were effectively foreclosed from access to the educational opportunities offered by the San Francisco public school system. Of the total of 2856 Chinese students with language deficiencies, about 1,000 received suplemental instruction and 1,800 received nothing. Lau v. Nichols, 414 U.S. 563, 564-66 and n.1 (1974).

§2000e-2 (1983),[7] and the Fair Housing Act "because of" language in 42 U.S.C. §3604(a), Title VIII of the Civil Rights Act of 1968.[8] Just as violations of Title VII and Title VIII may be shown by demonstrating the discriminatory effect of a challenged practice as well as by demonstrating discriminatory intent, so too violations of §504 may shown by demonstrating the discriminatory effect of a practice. As discussed below, statistics showing a gross or substantial impact on the basis of disability may give rise to a presumption of a nexus -- that is, that the grossly

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[7] Albermale Paper Co. v. Moody, 422 U.S. 405, 425 (1975); Griggs v. Duke Power Co., 401 U.S. 424, 431-432 (1971),

[8] Resident Advisory Board v. Rizzo, 564 F.2d 126, 148-150 (3d Cir. 1977), cert denied, 435 U.S. 908 (1978); Metropolitan Housing Dev. Corp. v. Village of Arlington Hts (Arlington II), 558 F.2d 1283, 1287-1290 (7th Cir. 1977) Cert. denied 434 U.S. 1025 (1978).

disparate need for more than 14 days of hospitalization is because of their handicapped status. By showing that the injury is by reason of handicap and by showing that the plaintiff is an "otherwise qualified handicapped individual," the plaintiff has satisfied by elimination the "solely" part of this element.

D. Adverse action cognizable under § 504

The breadth of the scope of § 504 and the adverse actions it reaches is reflected in its language as well as by the Health & Human Services regulation which Tennessee agreed to be bound by as a necessary condition to receiving federal financial assistance under the Medicaid program.[9]

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[9]See excerpts from the HHS § 504 Regulations, 45 C.F.R. Part 84, set out in the appendix.

1. "excluded from participation in" a federally assisted program

The program design absolutely excluded from participation in the Medicaid-covered inpatient hospital services program a group of persons defined in terms of the nature and severity of their handicap: otherwise qualified handicapped individuals who had used 14 days of inpatient hospital services in the relevant fiscal year and whose disability related medical need for inpatient services was comparable to or greater than the medical need of persons who were receiving inpatient hospital services under the program.

2. "denied the benefits of" a federally assisted program

The program design denied a class of otherwise qualified handicapped indi-

viduals defined in terms of the nature and severity of their disabilities the statutorily defined benefit of the State's Medicaid coverage of inpatient hospital services: coverage of medically necessary inpatient hospital services.[10] Such a class of otherwise qualified handicapped individuals was denied access to program benefits which were as effective as those enjoyed by their less disabled or nondisabled peers.

3. "subjected to discrimination under" a federally assisted program

The program design discriminated against the more severely handicapped segment of the Medicaid recipient popu-

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[10] See discussion at section II infra.

lation by shifting to their shoulders a disproportionate share of the overall cost burdens of medically necessary inpatient hospital services. The Tennessee Medicaid inpatient hospital services program would cover postponable elective surgery for someone who had not used up 14 days in one fiscal year, but would not cover disability related hospital services needed to preserve life or level of functioning if the otherwise qualified handicapped individual had used up his 14-day allotment.

4. Recipients are required to take affirmative steps to remedy the effects of discrimination.

Defendants/Petitioners contend that this Court's decision in Southeastern Community College v. Davis, 442 U.S. 397 (1979), demonstrates that § 504 does not require the provision of any affirmative

relief to eliminate the effects of discrimination against handicapped persons. That contention is wrong for several reasons.

Any statements in Davis remotely suggesting that Section 504 does not require affirmative remedies to eliminte discrimination against handicapped beneficiaries of federal programs must be read in light of Conrail v. Darrone, 104 S.Ct. 1248 (1984), in which this Court expressly held that amendments to the Rehabilitation Act, adding § 505 to the Act; 29 U.S.C. § 794a, incorporated into the Act the HEW regulations under § 504. Id., 104 S.Ct. at 1255. See 45 C.F.R. part 84. Those regulations, in addition to requiring aids and services to affirmatively accomodate the needs of handi-

capped persons,[11] specifically require "remedial action," defined by the regulations as actions "necessary to overcome the effects of the discrimination." 45 C.F.R. §84.6. Leaving no room for gainsaying, HEW's official commentary to this section states:

> Remedial action. Where there has been a finding of discrimination, § 84.6 requires a recipient to take remedial action to overcome the effects of the discrimination. Actions that might be required under paragraph (a)(1) include provision of services to persons previously discriminated against, reinstatement of employees, and development of a remedial action plan. Should a recipient fail to take required remedial action, the ultimate sanctions of court

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[11] E.g., 45 C.F.R. §84.11(b) (requiring that facilities be made architecturally accessible); id. § 84.34(a) requiring "supplementary aids and services" to enable handicapped children to be educated in a regular educational environment); id. §84.44(d) (requiring auxiliary aids for handicapped college students); id. §84.52(d) (requiring auxiliary aids for handicapped beneficiaries of larger health, welfare, and social services agencies).

> action or termination of federal financial assistance may be imposed.
>
> Paragraph (a)(2) extends the responsibility for taking remedial action to a recipient that exercises control over a noncomplying recipient. Paragraph (a)(3) also makes clear that handicapped persons who are not in the program at the time that remedial action is required to be taken may also be the subject of such remedial action. This paragraph has been revised in response to comments in order to include persons who would have been in the program if discriminatory practices had not existed.

45 C.F.R. part 84, Appendix A, ¶9.

In codifying this regulation, "Congress apparently determined that it would require...grantees to bear the costs" of eliminating discrimination against handicapped beneficiaries "as a quid pro quo for the receipt of federal funds." Conrail, 104 S.Ct. at 1254 n. 13.

Moreover, the sole issue actually determined by the Court in Davis was

whether Ms. Davis was "otherwise qualified" within the meaning of Section 504.[12] The Court thus did not decide the issue presented here, whether plaintiffs, who unquestionably satisfy all pertinent eligibility criteria under the Title XIX and state regulations, and thus are "otherwise qualified," have established a prima facie case of discrimination under Section 504.

It is manifest that the Court's holding in Davis was limited to the "otherwise qualified" issue. The court noted that "on the present record it appears unlikely respondent could benefit from any affirmative action" that

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[12]Judicial decisions discussing this question uniformly have recognized that the holding in Davis dealt only with the issue of whether plaintiff was "otherwise qualified." E.g., New Mexico Association for Retarded Citizens v. State of New Mexico, 678 F.2d 847, 853-54 (10th Cir. 1982); S-1 v. Turlington, 635 F.2d 342, 349-50 (5th Cir. Unit B, 1981), cert. denied, 454 U.S. 838 (1982).

the defendant college might have undertaken. Thus, the Court observed, even if such relief had been ordered, Ms. Davis "would not receive even a rough equivalent of the training a nursing program normally gives." Id. at 409, 410. For these reasons, the Court concluded that Ms. Davis would be unable to participate in the nursing program in any event, see id. at 407, and that she was therefore not an otherwise qualified handicapped individual. See id. at 406, 407.

Moreover, the language of the Davis decision is in fact consistent with the holding of Conrail. In Davis, the Court states:

> If [the HEW] regulations were to require substantial adjustments in existing programs beyond those necessary to eliminate discrimination against otherwise qualified individuals, they would do more than clarify the meaning of § 504.

442 U.S. at 410 (emphasis supplied). This language plainly recognizes that "adjustments in existing programs" may be required in some circumnstances by Section 504 when "necessary to eliminate discrimination against otherwise qualified individuals." Importantly, the Court noted that "situations may arise where a refusal to modify an existing program might become unreasonable and discriminatory." Id. at 412-13.

Finally, Petitioner also miscontrues the Court's observation in Davis that § 504, unlike §§ 501 and 503 of the Rehabilitation Act, does not refer to affirmative action. ID. at 442 U.S. at 410. To say that § 504 does not impose an affirmative action requirement, however, does not mean that Section does not require measures "to overcome the effects of discrimination" against handicapped persons, 45 C.F.R. § 84.6,

"includ[ing] provision of services to persons previously discriminated against," id., Appendix A, ¶9.

E. Burdens of Persuasion and Production in Plaintiff's § 504 case

A plaintiff of course would have the burden of proof with respect to any disputed element in plaintiff's case. Once the plaintiff submits evidence from which the trier of fact could find for the plaintiff with respect to such disputed elements,[13] the defendant would then have the burden of going forward with evidence legally sufficient to rebut the inference. Of course, the burden of persuasion would remain with the plaintiff.[14]

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[13] Texas Dep't of Community Affairs v. Burdine, 450 U.S. 248, 254-255 and n. 7, 8, 10 101 S. Ct. 1089, 1094-95 (1981).

[14] Id.

F. Burden of Persuasion shifts to Defendant with respect to Affirmative Defenses

Once plaintiff overcomes any rebuttal evidence and satisfies the trier of fact that he (or he and the class) is an "otherwise qualified handicapped individual" who, "solely by reasons of his handicap," has been "excluded from the participation in, ... denied the benefits of, or ... subjected to discrimination under any [federally assisted] program," the plaintiff has met his burden of persuasion. At that point a burden of persuasion is shifted to the defendant to show that the action was nonetheless justified.[15] Analysis of proof

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[15] New York Ass'n for Retarded Children v. Carey, 612 F.2d 644, 649-650 (2d Cir. 1979) (school board "obliged to make at least some substantial showing" that exclusion of Hepatitis B carriers justified); O'Connor v. Board of Education of School District 23, 449

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related to this stage was not reached below because the trier of fact concluded, inter alia, that the plaintiffs

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U.S. 1301, 1305, 101 S.Ct. 72, 74 (1980) (Justice Stevens as Circuit Justice) (Once plaintiff established school refused to allow her to try out for the boy's team solely because she is female, burden of justification on defendants); Resident Advisory Board v. Rizzo, 564 F.2d 126, 148-150 (3d Cir. 1977) cert. denied, 435 U.S. 908 1978) (under Title VIII, 42 U.S.C. §§ 3601 et seq., §3604(a), once plaintiff establishes discriminatory effect, burden of establishing justification shifts to defendant; "a justification must serve, in theory and practice, a legimate, bona fide interest of the Title VIII defendant, and the defendant must show that no alternative course of action could be adopted that would enable that interst to be served with less discriminatory impacts").

had not made out a prima facie case.[16] In order to show that otherwise discriminatory action was necessary, a defendant may be required to show that the foreseeable consequences of the program design on the protected class were considered and that no alternative design with lesser adverse consequences that met the program's necessary and legitimate needs had been identified. By way of rebuttal, plaintiff could identify less discriminatory alternatives which could defeat defendant's evidence that the program design was justified by necessity.

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[16] Jennings v. Alexander, supra, 518 F.Supp., at 881 ("the court finds that the plaintiffs have failed to carry their burden of establishing that the limitation of 14 days of hospital coverage will in fact have a discriminatory impact upon handicapped Medicaid recipients").

II.

THE INPATIENT HOSPITAL SERVICES PROGRAM IS NOT A FLAT VOUCHER PROGRAM; RATHER IT IS A PROGRAM WHICH COVERS THE COST OF SUCH SERVICES BASED ON NEED.

Equal access to program benefits for purposes of § 504 is defined by looking first at the program itself, including the program objectives against which the program's activities are measured. This Court in Southeastern Community College v. Davis, 442 U.S. 397, 408-410, 99 S.Ct. 2361, 2368-69 (1979), defined the benefits of the nursing course of study in terms of the program's training objectives. The scope of the overall Title XIX Medicaid program and of the particular program at issue herein -- inpatient hospital services[17] -- and

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[17] "inpatient hospital services (other than services in an institution for tuberculosis or mental diseases)," 42 U.S.C. § 1396d(a)(1) (1983); Cf. Doe v. Colautti, 592 F.2d 704 (3d Cir. 1979)
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eligibility requirements is defined by Title XIX. Title XIX defines the purpose at 42 U.S.C. § 1396 which provides in relevant part:

> enabling each State, as far as practicable under the conditions in such state, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, ...

Inpatient hospital services is one of five mandatory services Title XIX requires participating states to cover.[18] Persons who are categorically

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(Footnote from previous page) (for purposes of determining whether or not a person was denied equal access or otherwise discriminated against with respect to Medicaid inpatient hospital services, look to the Medicaid statute to define the scope of the particular program at issue).

[18] Inpatient hospital services; outpatient hospital services including rural health clinic services; laboratory and x-ray services; skilled nursing facility services, early and periodic screening for persons under age 21, family planning services; physicians' services. 42 U.S.C. § 1396d(a)(1)-(5).

needy -- recipients of Supplemental Security Income (SSI)[19] and Aid To Families with Dependent Children (AFDC)[20] -- are required to be covered.[21]

The "language [of the statute[22]] confers broad discretion on the States

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[19]Title XVI of the Social Security Act, 42 U.S.C. § 1381 et seq.

[20]Title IV of the Social Security Act, 42 U.S.C. § 601 et seq.,

[21]42 U.S.C. § 1396a(a)(10)(A)(i). At the State's option persons who are medically needy may also be covered: Persons who would be eligible for one of the categorical programs but for income -- e.g., a recipient of Social Security Disability Income (SSDI) under Title II of the Social Security Act, 42 U.S.C. § 401 et seq., in an amount above the SSI grant level but who meets all the other eligibility requirements of SSI. 42 U.S.C. § 1396a(a)(10)(A)(ii) (1983).

[22]"A State plan for medical assistance must ... include reasonable standards .. for determining eligibility for and the extent of medical assistance under the plan which ... are consistent with the objectives of this [Title]...." 42 U.S.C. § 1396a(a)(19) (1983). "A State plan for medical assistance must ... provide such safeguards as may be

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(Footnote cont from previous page) necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(17) (1983).

A court reviewing a state plan -- including a 14-day limitation on inpatient hospital services -- under Title XIX alone presumes conformity if the standard "is 'not irrational or arbitrary and counterproductive to the medical well-being of all Medicaid recipients.'" Jennings v. Alexander, 715 F.2d 1036, 1045 (6th Cir. 1983), citing Budnicki v. Beal, 450 F.Supp. 546, 557 (E.D. Pa. 1978), and Philadelphia Welfare Rights Organization v. O'Bannon, 517 F.Supp. 501, 508 (E.D.Pa. 1981), aff'd, 681 F.2d 808 (3d Cir. 1982). However, § 504 introduces another factor into the reasonableness calculus: A requirement that consideration be taken of the impact on the handicapped -- here the disabled SSI recipients. Under § 504 the State's failure even to consider the foreseeable impact of the 14-day limitation renders the limitation unlawful:

> Agencies' actions must be rational and reasonable, and in order to assure that their actions are not arbitrary, agencies must pay adequate attention to all factors made relevant and material by the statutes under which they operate. See, generally, 4 K.Davis, Administrative Law Treatise, §§ 29.00-29.00-5 (Supp. 1982), and cases cited therein; Pierce & Shapiro,

to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the Act. *** [However,] serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment...." Beal v. Doe, 432

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Political and Judicial Review of Agency Action, 59 Tex. L.Rev. 1175, 1180-89 (1981).

Thomas v. Johnston, 557 F.Supp. 879, 910 (W.D. Tex. 1983). See also Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 412, 416 (1971) (determining whether agency action was arbitrary or capricious requires consideration of whether based on relevant factors); Illinois Hosp. Ass'n v. Illinois Dep't of Public Aid, 576 F.Supp. 360 (N.D. Ill., E.D. 1983) (preliminary injunction based on likelihood of prevailing on claim that hospital rates are arbitrary and unreasonable because failed to consider factors identified in statutes); California Hosp. Ass'n v. Schweiker, 559 F.Supp. 110 (C.D. Cal. 1982) (hospital rates invalid as arbitrary and capricious because of failure to consider all relevant factors).

U.S. 438, 442, 97 S.Ct 2366, 2370, 53 L.Ed.2d 464 (1977). Only necessary care and services are to be provided under the state Medicaid plan. "A State plan for medical assistance must ... provide such methods and procedures relating to the utilization of ... care and services available under the plan ... as may be necessary to safeguard against unnecessary utilization of such care and services...." 42 U.S.C. § 1396a(a)(30) (1983).

The State's and United State's characterization of the program is wrong in several respects. First, it is not a program comparable to a voucher program where a fixed, across-the-board sum is given to be spent, if needed, in the medical marketplace.[23] Rather the

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[23] Brief of United States, p. 13: "Suppose Tennessee were to decide that it wished to give each of its citizens $100, to be spent on health care, ..."

dollar amount actually expended on inpatient hospital services under the Medicaid program is based on individual need: the level of acute care (i.e., regular or intensive care unit), the number and kinds of support and monitoring machines the patient is hooked up to, the types of services and treatment provided, the number of days needed, and the hospital billing rates.[24]

Second, the State, despite the United States' representations to the contrary,[25] does not have an unfettered discretion to define the "benefits" of its Medicaid program. While the State's discretion with respect to "reasonableness" and recipients' "best interests"

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[24]Thus two people needing the same number of inpatient days may end up with widely divergent inhospital services costs.

[25]Brief of United States, pp. 12-13.

may be insulated from judicial scrutiny under Title XIX alone by an "arbitrary and capricious standard,"[26] under § 504 and given the impact on individual otherwise qualified handicapped individuals[27] who are and will be hurt by the 14-day limitation solely because of the nature and severity of their handicapping conditions, those provisions are

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[26]See discussion at note 22, supra.

[27]Although the disparate impact of the program design is demonstrated statistically, it is otherwise qualified handicapped individuals who are hurt by the program design solely because of the nature and severity of their handicapping condition. Their right to be free of discrimination cognizable under § 504 is an individual right just as the right to be free of discrimination cognizable under Titles VI and VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. §§ 2000d et seq., §§ 2000e et seq, is an individual right. Regents of the University of California v. Bakke, 438 U.S. 265, 416 n.19 (1978) (Stevens-Burger-Stewart-Rehnquist opinion, individual character of Title VI rights); City of Los Angeles, DWP v. Manhart, 435 U.S. 702, 708 (1978) (Title VII, "statute's focus on the individual is unambiguous").

looked at under a civil rights glass and their substantive content given effect to define the program and the benefits thereunder.

Third, designing the program so that all Medicaid recipients have comparable coverage of their medically necessary inpatient hospital services[28] does not mean that those with minimal hospital usage needs are "subsidizing" those disabled SSI recipients whose disabilities require hospitalization in excess of 14 days.[29] Similarly the Defendant in

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[28]Comparable coverage within the state defined fiscal limitations are matters to be addressed as part of defendants' affirmative defense case. The plaintiffs had identified a less discriminatory alternative which would, apparently, mesh more efficaciously with Hill-Burton funded inpatient hospital services. Adoption of a more restrictive definition of medical necessity is another cost containment stratagem used more frequently than the fixed-day limitation stratagem sought to be employed here.

[29]Brief of the United States, pp. 22-25.

Mills v. Board of Education, 348 F. Supp. 866, 875 (D.D.C. 1972), argued it could not provide an appropriate education to the 18,000 of the district's 22,000 handicapped children in need of a special education because the reallocation of funds to do so would be inequitable to non handicpped. The Court rejected that argument:

> "If sufficient funds are not available to finance all of the services and programs that are needed and desirable in the system then the available funds must be expended equitably in such a manner that no child is entirely excluded from a publicly supported education consistent with his needs and ability to benefit therefrom. The inadequacies of the District of Columbia Public School system whether occasioned by insufficient funding or administrative inefficiency, certainly cannot be permitted to bear more heavily on the "exceptional" or handicapped child than on the normal child."

Id., at 876. By its terms the Medicaid program's purpose is to address the risk exposure the identified populations face

with respect to necessary medical services because of insufficient income and resources.[30] Disabled SSI recipients who are more likely to need hospitalization in excess of 14 days than are non-handicapped are only "subsidized" in the sense that a city's homeowners subsidize fire protection for those who live in higher fire risk foothills, or subsidize police protection for those who live in an area with a higher crime rate. Under the terms of the Medicaid statute, equal access relates to the coverage of the risk exposure related to medically necessary inpatient hospital services. A

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[30] See 42 U.S.C. § 1396 quoted in relevant part in section II at p. supra. The "as far as practicable" language therein goes to the State's justification for designing and adhering to a program which disparately impacts on disabled SSI recipients -- a class of handicapped persons defined in terms of the nature and severity of their disability.

design which unfairly distributes risk burdens has unfairly distributed the benefits of risk protection.[31]

III

THE 14-DAY LIMIT ON MEDICAID INPATIENT HOSPITAL SERVICES HAS A DISCRIMINATORY EFFECT ON THE BASIS OF PLAINTIFFS' HANDICAP.

The evidence in this case leads ineluctably to a conclusion that plaintiffs have established a prima facie case of discrimination.

First, the evidence indicates that no thought or consideration was given to the impact on handicapped persons of a reduction from 20 to 14 days in Medicaid

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[31]Even should a fairer distribution of risk protections and burdens result in an adverse impact on the basis of, say, race, no Title VI violation could be made out because no showing could be made that anyone was injured -- i.e., denied a level of inpatient hospital services available to someone else.

inpatient hospital services.[32] At a minimum, the Medicaid statutory requirements of "reasonable standards" and program design in the recipients' "best interests", the identification of SSI recipients as a discrete group among those who are to be categorically linked to the Medicaid program, plus § 504, require the State to consider the impact on the handicapped of a particular method of reducing the cost of benefits. Even disparate treatment discrimination is not limited to situations where there is a discriminatory animus toward persons with disabilities. Being overlooked, avoided, and ignored are among the kinds of discrimination the legislative history

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[32] Jennings v. Alexander, supra, 715 F.2d at 1044.

indicates § 504 sought to address.[33] Thus although the provisions of § 504 and Title XIX when read together impose an obligation to consider the impact on handicapped when designing a method of allocating limited health services

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[33] E.g., "The State governments discriminate by their apathy." Representative Vanick, 119 Cong. Rec. 2999 (1973). See also Pushkin v. Regents of Univ. of Colo., 658 F. 2d 1372 1385 (10th Cir. 1981):

> "It would be a rare case indeed in which a hostile discriminatory purpose or subjective intent to discriminate solely on the basis of handicap could be shown. Discrimination on the basis of handicap usually results from more invidious causative elements and often occurs under the guise of extending a helping hand or a mistaken, restrictive belief as to the limitations of handicapped persons."

resources,[34] the state failed to do so.[35] The consequence of that failure was to shift a grossly inequitable burden on a class defined in terms of the nature and severity of their disability: disabled recipients of SSI who because of their disability need inpatient hospital services in excess of 14 days in any one year. Indeed, even a finding of intentional discrimination has been sustained on comparable evidence: statistics indicating a gross disparate impact[36] coupled with a system amenable to abuse.[37]

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[34] See note 22, supra.

[35] See note 32, supra.

[36] See Section IV, infra.

[37] Castaneda v. Partida, 430 U.S. 482, 494, 97 S.Ct. 1272, 1280 (1977) (substantial under representation plus "a selection procedure that is

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Second, reducing the Medicaid inpatient hospital services from 20 to 14 days without any provision for exceptions in cases of exigent medical necessity -- such as conditions which would be life threatening in the absence of inpatient hospital services -- operate to deny otherwise qualified handicapped individuals the intended program benefit: medically necessary inpatient hospital services. In Beal v. Doe, 432 U.S. 438 (1977), this Court noted that "serious statutory questions might be presented if a state Medicaid plan

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susceptible of abuse..."); Turner v. Fouche, 396 U.S. 346 (1970) (substantial disparity plus use of subjective criteria to create jury list); Searcy v. Williams 656 F.2d 1003, 1009 (5th Cir. Unit B 1981), aff'd sub nom. Hightower v. Searcy, ___ U.S. ___, 102 S.Ct. 1605 (1982) (failure to appoint blacks to school board, substantial disparity plus "discretionary element in the administration of the legislation."

excluded necessary medical treatment from its coverage" (Id., at 444, 97 S.Ct. at 2371). Although the Court upheld the right of the state to deny nontherapeutic abortions -- namely abortions which were not medically necessary in order to protect the life of the mother, this case raises a strikingly different question. Here the State is denying indisputedly medically necessary services -- inhospital services necessary to protect the life of the recipient -- because the nature and severity of the handicapping conditions calls for inpatient hospital services in excess of 14 days in a given year. While the State has broad discretion in defining what constitutes "medical necessity" consistent with its utilization control responsibilities,[38] certainly that dis-

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[38] 42 U.S.C. § 1396a(a)(30).

cretion does not include defining as no longer medically necessary services needed to protect life simply because of crossing a 14-day threshhold.

Third, the 14-day limitation design of the program denies plaintiffs and the class they represent an opportunity to receive medically necessary services comparable to the opportunity enjoyed by their nonhandicapped peers. Inpatient hospital services benefits are covered on the basis of medical necessity as defined and monitored by the State.[39] Plaintiffs and class members who, because of the nature and severity of their handicapping condition require more than 14 days of hospital services, are denied a level of Medicaid coverage commensurate with their level of medical

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[39] Id.; Beal v. Doe, 432 U.S. 438, 442, 97 S.Ct. 2366, 2370 (1977).

need level. They are denied coverage benefits which are as effective as the coverage provided other recipients whose needs can be met within the 14-day limitation.

IV.

PLAINTIFFS' STATISTICS INDICATING A DISPARITY OF 28 STANDARD DEVIATIONS MADE OUT A PRIMA CASE OF DISPARATE IMPACT ON THE BASIS OF HANDICAP.

A. Evidentiary role of adverse impact statistics

Adverse impact statistical evidence is merely a means for establishing a causal connection between the adverse impact criterion and the adverse impact itself. Adverse impact statistics have been used as evidence establishing discriminatory intent[40] and as evidence

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[40] Castaneda v. Partida, 430 U.S. 482 (1977) (presumption of intentional discrimination in grand jury selection

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establishing that a practice which is fair in form is discriminatory in operation.[41]

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where County's population was 79.1% Mexican-American but only 39% of those summoned in an 11-year period were Mexican-American); Teamsters v. United States, 431 U.S. 324 (1977) (pattern or practice of racially premised hiring for over-the-road line driving positions established inter alia by workforce statistics showing that of the line drivers, .4% were black and .3% latino); Hazelwood School District v. United States, 433 U.S. 299, 306 n.14 (1977) (prima facie case of a practice of discrimination in hiring teachers established inter alia by evidence indicating that although 5.7% of the teachers in the area were black, blacks constituted only 1.4% and 1.8% of the school's teaching workforce over a two-year period -- representing more than six and five standard deviations respectively).

[41] Albemarle Paper Co. v. Moody, 422 U.S. 405, 425 (1975); Griggs v. Duke Power, 401 U.S. 424, 432 (1971); Resident Advisory Board v. Rizzo, 564 F.2d 126, 148-150 (3rd Cir. 1977).

Compare Lau v. Nichols, 414 U.S. 563 (1974), where the disparate effect of San Francisco's school system on non-English speaking Chinese students was determined without the need for comparison statistics.

B. Relevant statistics are those relating to Medicaid hospital users

Petitioner/Defendant argues that there is no disparate impact because "95% of all 'eligible' handicapped Medicaid recipients would have all their inpatient hospital needs met as the 14-day limitation."[42] However, reliance on statistics indicating the 14-day maximum has a lesser the impact on the overall medicaid population is misplaced. Persons who are "otherwise qualified" for purposes of the hospitalization medicaid program are those who have satisfied all the medicaid eligibility requirements and who have been determined to need acute level care as evinced by their

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[42]Brief of Petitioners, p. 21.

admission to the hospital. The comparisons of "otherwise qualified" or hospitalization-eligible groups are more finely tuned than are the over-all medicaid population comparisons and therefore a more reliable index.

C. Adverse impact is gross

In the 1979 benchmark year, of the 16,852 handicapped[43] medicaid recipients

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[43]The group classified as "handicapped" are those SSI recipients who are under age 65 and thus receiving SSI solely because of the chronicity and severity of their disability (the statutory standard is inability for a year or more to engage in any substantial gainful activity -- i.e., inability to hold down a minimum wage job) and who were hospitalized under Medicaid in the 1979 benchmark year. The "nonhandicapped" population includes AFDC recipients and 1,833 SSI recipients who are over age 65 and were hospitalized under Medicaid.

than 14 days. The disparity is gross[44] as reflected in the fact that it represents 28 standard deviations -- virtually the same as the 29 standard deviations found to make out a prima facie case of intentional discrimination in Castaneda v. Partida, 430 U.S. 482

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[44]Although the handicapped population constituted one third of the Medicaid recipients who were hospitalized under the program, that population constituted two thirds of those who would be denied an opportunity to realize program benefits comparable to that afforded those whose hospitalization needs could be met within a 14-day limitation. The disparity also would constitute "disparate impact under the 'eighty percent rule' of the Uniform Guidelines on Employee Selection Procedures adopted by the Equal Employment Opportunity Commission. ... Those guidelines provide that a selection rate that 'is less than [80 percent] of the rate for the group with the highest rate will generally be regarded ... as evidence of adverse impact.' 29 CFR § 1607.4D (1981)." Connecticut v. Teal, 457 U.S. 440, ____ n. 4, 102 S.Ct. 2525, 2529 n. 4 (1982).

(1977).[45] That gross disparity -- which was buttressed by medical testimony[46] -- gives rise to a presumption of a causal connection between protected class status and the adverse impact of the 14-day limitation criterion -- that is, that the differential impact was by reason of the SSI recipients' disability.

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[45]This conclusion is reached by applying the approach detailed in Castaneda v. Partida, 430 U.S. at 496 n. 17: (1) Add together handicapped and nonhandicapped to reach total sample size -- 51,140; (2) add together handicapped and nonhandicapped figures to reach total needing more than 14 days -- 7,279 which is ca. 14.22 percent of the total; (3) Applying 14.22% to the total sample size, the representation of those in the handicapped classification needing more than 14 days should be 2396 (.1422 x 16,852); (4) The amount in excess (difference between those in the handicapped classification actually needing hospitalization and 2396) is 2221; (5) The standard deviation is the square root of 51,140 x .1422 x (1.0 -.1422 or.8578) -- or 79; (6) The number of standard deviations is the differential (2221) divided by 79.

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D. Defendant conceded that its 14-day limitation disparately impacted on the basis of handicap and failed to come forward with any evidence to rebut plaintiffs' statistical proof.

Hazelwood School District v. United States, 433 U.S. 299, 308-13 (1977), tells us that once plaintiffs as here come forward with statistical evidence giving rise to a presumption that the adverse impact on disabled SSI recipients needing hospitalization was because of their protected class status, shifted

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[46]Medical testimony also indicated that the reason the SSI disabled group had greater need of inpatient hospital services was because of their disability. Jennings v. Alexander, supra, 715 F.2d at 1042-44. See also Pouncy v. Prudential Insurance Co. of America, 668 F.2d 795, 800-01 (5th Cir. 1982), which requires a plaintiff as part of his prima facie case to show the causal connection between the protected class status and the adverse impact resulting from the application on the protected class of the criterion at issue -- here the 14-day limitation.

to defendants is a burden of producing evidence to rebut the prima facie statistical proof.[47] While the plaintiff must demonstrate the meaningfulness of the statistical comparisons, they need not present a perfect statistical analysis at the prima facie stage. Dothard v. Rawlinson, 433 U.S. 321, 331 (1977). The district court dismissed the plaintiffs' statistics based on an asserted failure to prove as part of their prima facie case two speculative negatives: One, that the 1979-80 inpatient hospital usage statistics were not aberrational,[48] and two, that the higher level of need for inpatient hospital services was not

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[47] Hazelwood School Dist. v. United States, supra; Dothard v. Rawlinson, 433 U.S. 321, 331 (1977); Craig v. County of Los Angeles, 626 F.2d 659, 664-665 (9th Cir. 1979), cert. denied, 450 U.S. 919 (1981).

[48] Brief of Petitioners at p. 6 indicates Medicaid remained constant from FY 1975-76 through FY 1980-81.

for reasons unrelated to handicap.[49] Although defendants had ample opportunity[50] at trial to rebut plaintiffs' statistical case by arguably more finely tuned, probative statistics,[51]

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[49] Jennings v. Alexander, supra, 518 F.Supp. at 881-882.

[50] Davis v. Califano, 613 F.2d 957, 964 (D.C. Cir. 1980) ("Defending party, with the greater access to statistical evidence of other relevant factors, may utilize such evidence in its rebuttal presentation").

[51] More probative evidence might have resulted from a coupling of the hospital utilization statistics with a random sampling of the utilization control/admission records to determine by days of stay the extent to which hospitalization was related to disability -- i.e., was because of handicap, and the extent to which hospitalization in the senior SSI group included within the nonhandicapped classification was related to disability and therefore also because of handicap. Such disability related determinations are commonly done by states for children and young adults covered by state Crippled Children's Services programs under Title V of the Social Security Act, 42 U.S.C. §§ 701 et seq., to determine whether the hospitalizations would be covered under the program.

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defendants failed to do so suggesting that such statistics would have reinforced plaintiffs' case. Indeed, defendants conceded that the reduction to a 14-day limit would have a disparate impact on the basis of handicap.[52]

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Thus in California bladder infections and decubitus ulcer infections are recognized as related to the status of being para and quadriplegic; pneumonia is recognized as related to a range of disabilities such as cystic fibrosis and chest area paralysis fostering fluid buildup in the lungs. Thus while arguably some of the hospital admissions of the group designated "handicapped" were not for a reason related to their disabilities and therefore a need for hospitalization in excess of 14 days would not be because of handicap, this would be more than offset by hospital admissions from the over-age-65 group among those designated "nonhandicapped" which were in fact related to a disability comparable in terms of the nature and severity to the disabilities of the SSI disabled group.

[52] Jennings v. Alexander, supra, 715 F.2d at 1042, n.7.

Further, as the Court of Appeal noted (715 F.2d at 1043), the statistical evidence was buttressed with "medical testimony which described the inpatient hospitalization pattern of patients with certain handicaps.

CONCLUSION

For the reasons set forth in Respondents' briefs, companion amici briefs, and above, the amici indpendent living centers respectfully urge that the decision of the Sixth Circuit be affirmed.

DATED: JULY 19, 1984

Respectfully submitted,

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APPENDIX

The HHS regulations at 45 C.F.R. § 84.52(a) (1983) under Subpart F--Health, Welfare, and Social Services, provide

> In providing health, welfare, or other social services or benefits, a recipient may not, on the basis of handicap,
>
> (1) Deny a qualified handicapped person these benefits or services;
>
> (2) Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered nonhandicapped persons;
>
> (3) Provide a qualified handiapped person with benefits or services that are not as effective (as defined in § 84.4(b), as the benefits or services provided to others;
>
> (4) Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons; or
>
> (5) Provide different or separate benefits or services to handicapped persons except where necessary to provide qualified handicapped persons with benefits and services that are as effective as those provided to others.

Section 84.4(b)(2) provides

> For purposes of this part, aids, benefits, and services, to be equally effective, are not required to produce the identical result or level of

achievement for handicapped and nonhandicapped persons, but must afford handicapped persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement, in the most integrated setting appropriate to the person's needs.

Section 84.4(b)(4) provides in relevant part

> A recipient may not, directly or through contractual or other arrangements, utilize criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect to handicapped persons, ...

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copies of the foregoing Brief of the Amici have been mailed this 19th Day of July 1984, to the below-referenced counsel.

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No. 83-727

IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

LAMAR ALEXANDER, Governor of the
State of Tennesse, et al.,

Petitioners,

– against –

Hershel Choate substituted for
ROSIER JENNINGS, deceased, et al.,

Respondents.

BRIEF OF *AMICUS CURIAE* UNITED CEREBRAL PALSY OF NEW YORK CITY, INC.

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No. 83-727

IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

LAMAR ALEXANDER, Governor of the State of Tennesse, et al.,

Petitioners,

– against –

Hershel Choate substituted for ROSIER JENNINGS, deceased, et al.,

Respondents.

INTEREST OF AMICUS CURIAE

United Cerebral Palsy of New York City, Inc. ("UCP") files this brief, *amicus curiae*, pursuant to Rule 36 of the Rules of the Supreme Court, in support of plaintiffs below.[1] UCP is a not-for-profit corporation which provides direct educational, medical, vocational, recreational, transportation and other services to over 2,000 children and adults afflicted with Cerebral Palsy and related handicaps resident in the City of New York. In addition, the agency conducts public and professional education and advocacy programs to promote the interest of the cerebral palsied and other handicapped persons.

[1] Letters of consent to the filing of the brief have been lodged with the Clerk of the Court.

The issues concerning the application of a disparate impact standard to programs receiving federal financial assistance under § 504 of the Rehabilitation Act directly affect the funding and operation of virtually all of UCP's programs. UCP also believes that its unique experiences as being simultaneously both a provider and an advocate enable it to bring to the Court important perspectives on the manner in which a disparate impact standard may protect the rights of the handicapped with due recognition for reasonable cost constraints.

STATEMENT OF THE CASE

Reacting to fiscal cutbacks in its federally funded Medicaid program, the State of Tennessee's Medicaid administrators decided to reduce the number of inpatient hospital days provided to each eligible recipient from 20 to 14. Together with other program reductions, this change was scheduled to go into effect on August 15, 1980. Studies prepared by the Medicaid program and introduced into evidence below indicated that if put into effect for the prior year, this change would have detrimentally affected 27.4 % of all handicapped hospital users and only 7.8 % of the non-handicapped.

The Court of Appeals for the Sixth Circuit, reversing the District Court, held that those facts constituted a "disparate impact" on the handicapped under § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794). The Court remanded the case for further proceedings to provide defendants an opportunity to meet their burden of showing that there was a "substantial justification" for this particular cost limitation policy, especially in light of plaintiffs' allegations that an alternate policy, based on limiting the number of days in each stay, would produce equivalent cost savings with substantially less impact on the handicapped.

The specific issues before this Court are whether a "disparate impact" standard is the appropriate test for determining violations of § 504, and, if so, whether such a test was properly applied by the Sixth Circuit to the facts of this case.

SUMMARY OF THE ARGUMENT

Petitioners have erroneously applied to the context of discrimination against the handicapped political theory constructs borrowed from the race discrimination context, such as "equality of opportunity" versus "equality of result." Similarly, the legal doctrine of "discriminatory intent" is difficult to apply in the handicapped context because it is almost impossible in a particular situation to differentiate invidious animus from benign sympathy and/or overapplication of policies applicable to one subcategory of the handicapped to another. It is no coincidence, therefore, that virtually every court which has considered the issue has applied a "disparate impact" or "substantial justification" standard, and no court has applied a discriminatory intent standard.

"Disparate impact" is a meaningful approach for analyzing allegations of discrimination against the handicapped. It is essentially a "process" standard which provides the flexibility necessary to clarify complex liability issues and to construct practical remedies appropriate to the broad diversity of handicapping conditions. It permits a decision maker to consider whether alleged aggrievements stem from unreasonable policies or from limitations inherent to the disabling condition. The financial, political and administrative costs of proposed alternatives can best be weighed through a disparate impact analysis. The disparate impact approach is also fully consistent with this Court's emphasis in *Southeastern Community College v. Davis*, 442 U.S. 397 (1979) upon careful balancing of relevant considerations to determine the extent to which "reasonable accommodations" should be undertaken to meet the needs of the handicapped.

Application of a disparate impact standard is consistent with the legislative history of § 504. Although § 504 was patterned generally after Title VI of the 1964 Civil Rights Act, which this Court ruled in *Guardians Association v. Civil Service Commission*, 103 S.Ct. 3221 (1983) must be read to incorporate a discriminatory intent standard, the distinctive history and context of the passage of § 504 preclude an assumption that Congress meant to apply an intent standard to the handicapped context, where it would have little operational significance. Moreover,

since at the time of the passage of § 504 (and continuing to date), the Court had not articulated a constitutional standard for assessing claims of discrimination against the handicapped, there is no basis for concluding that Congress meant to incorporate a constitutional standard into the statute, as it did with Title VI. Finally, consistent with the views of a majority of the members of this Court in *Guardians*, even assuming *arguendo*, an "intent" reading of the statute, the disparate impact standard in the applicable federal agency regulations was still properly upheld by the Court below.

The Sixth Circuit's specific application of a disparate impact standard to the facts of this case was proper and imposed a minimal burden on defendants. In fact, defendants' burden of proof here was substantially less than the burden imposed on defendants in analogous situations arising under Title VI or Title VII of the 1964 Civil Rights Act. Defendants were not required on remand to consider all possible alternatives or to consider any alternatives which would not produce equivalent cost savings; they were merely asked to provide a "substantial justification" for a policy found to have a disparate impact on the handicapped in light of plaintiffs' proferred alternative which allegedly would result in equivalent cost savings to the State.

POINT I

DISPARATE IMPACT IS THE APPROPRIATE APPROACH FOR DETERMINING A PRIMA FACIE VIOLATION OF § 504

The critical concern underlying the positions of the petitioners, the United States as *amicus curiae*, and the District Court below is that adoption of a disparate impact standard in cases involving the handicapped will establish a right to "equality of results" rather than "equality of opportunity." Such an approach allegedly would require the State "to achieve identical results" for handicapped and non-handicapped recipients," (Petitioners' Brief at 24; Brief of the United States as *amicus curiae* at 21, *Jennings v. Alexander*, 518 F.Supp. 877, 883 (N.D. Tenn. 1981)) and "combining an equality of result standard with

a disparate impact test means the plaintiff always wins," *Jennings v. Alexander*, 715 F.2d 1036, 1049 (6th Cir. 1983) (Merritt, J., dissenting); Petitioners' Brief at 25.

These concepts of "equality of opportunity" and "equality of result,' upon which petitioners rely, are political theory constructs emerging from, and relevant to, problems of discrimination against racial minorities. *See, e.g.*, J.R. Pole, *The Pursuit of Equality of American History*, 351, 358 (1978). Although notions of discrimination in the two contexts are, of course, not totally unrelated, "attempting to fit the problem of discrimination against the handicapped into the model remedy for race discrimination is akin to fitting a square peg into a round hole..." *Garrity v. Gallen*, 522 F.Supp. 171, 206 (D.N.H. 1981).

The Court of Appeals for the Sixth Circuit recognized these distinctions and based its ruling on the statutory intent and applicable regulatory standards as they relate to the state's specific actions in this case and their impact on the handicapped. The Court eschewed "wooden notion[s] of access," 715 F.2d 1036, 1043 n. 8, and other egalitarian concepts which the District Court and the dissent had borrowed from the race discrimination context;[2] instead it applied a disparate impact standard that calls for a reasonable consideration of whether the needs of the handicapped Medicaid patients were fairly considered by the defendants when they adopted the 14-day limitation.

A. DISCRIMINATORY INTENT IS NOT A MEANINGFUL STANDARD IN REGARD TO THE HANDICAPPED

In *Washington v. Davis*, 426 U.S. 229 (1976), this Court held that state actions challenged as racially discriminatory under constitutional equal protection standards would invoke rigorous, strict scrutiny review only where a discriminatory impact on a minority

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[2] Justice Rehnquist's opinion for the majority, in *Board of Education v. Rowley*, 458 U.S. 176, 198 (1982), similarly rejected a wooden "equal opportunity" interpretation of the Education of the Handicapped Act which had been adopted by the lower courts in that case because " 'equal' educational opportunities would thus seem to present an entirely unworkable standard requiring impossible measurements and comparisons."

group was accompanied by a showing of an invidious discriminatory intent. Petitioners, in essence, ask this Court to extend the *Washington v. Davis* intent/impact distinction from the racial discrimination context to the handicapped discrimination context.

In pressing for this extension, petitioners do not discuss the special factors affecting discrimination against the handicapped, or the legislative history of § 504; nor have they cited any previous decisions of this Court, or indeed of any lower federal courts, that would require a showing of discriminatory intent in order to establish liability on behalf of a handicapped plaintiff. On the contrary, virtually every court which has articulated a standard for assessing claims of discrimination under § 504 has either explicitly delineated a disparate impact or "effects" standard, or has set forth a requirement for a showing of "substantial justification," a burden of proof requirement that is premised on an implied disparate impact finding. *See, e.g., Bentivegna v. United States Dep't. of Labor*, 694 F.2d 619 (9th Cir. 1982) (job qualifications that "adversely affect the handicapped" must be vigorously scrutinized); *New York State Ass'n for Retarded Children v. Carey*, 612 F.2d 644 (2d Cir. 1979) (showing of "detrimental effects" on retarded children requires "substantial showing" of policy's justification); *NAACP v. Medical Center, Inc.*, 657 F.2d 1322, 1331 (3d Cir. 1981) (Rehabilitation Act calls for application of an impact test); *Lynch v. Maher*, 507 F. Supp. 1268, 1279 (D.Conn. 1981) ("substantial justification" required to ban quadriplegic from home care program); *Larry P. v. Riles*, 495 F. Supp. 926, 966-973 (N.D.Cal. 1979), (application of "effects test" to educational testing).[3] All of these cases were decided after *Washington v. Davis* and none of them considered

[3] Indeed, even the District Court opinion in this case agreed that "a disparate impact test is the appropriate standard to apply in a § 504 case..." 518 F.Supp. at 885. Judge Morton denied relief to the plaintiffs because, in his view (despite the explicit concession on this issue by the defendants), a *prima facie* case of disparate impact against an appropriately defined group of the handicapped had not been established. *See also*, Brief of the United States as *amicus curiae* at 7-8.

the intent/impact distinction articulated there to be relevant in the handicapped context.

The reason why the courts have consistently applied a disparate impact standard to cases involving the rights of the handicapped is not difficult to fathom: the legal concept of "discriminatory intent," although sometimes difficult to establish in the context of racial discrimination, is virtually impossible to apply in the context of discrimination against the handicapped, as a group. Although the handicapped have, at times, been victims of invidious discrimination, *see, e.g.*, Kriegel, *Uncle Tom and Tiny Tim: Some Reflections on the Cripple as Negro*, 38 Am. Scholar 412 (1969); United States Commission On Civil Rights: *Accommodating The Spectrum Of Individual Abilities*, Ch. 2 (1983), most of the discrimination faced by handicapped individuals stems from non-invidious stereotyping which assumes that characteristics generally attributable to people with a particular handicapping condition will apply to all individuals with the condition (*see, e.g., Strathie v. Department of Transportation*, 716 F.2d 227 (3d Cir. 1983) (assumption that problems of hearing impairment cannot be sufficiently corrected to meet safety standards for bus drivers); *Costner v. United States*, 555 F.Supp. 146 (E.D.Mo. 1982), *rev'd* 720 F.2d 539 (8th Cir. 1983) (assumption that all epileptics are not reasonably capable of driving trucks in interstate commerce); *Coleman v. Casey County Board of Education*, 510 F.Supp. 301 (W.D.Ky. 1980) (assumption that amputee with artificial leg could not drive a bus safely), or from a well-intentioned, though sometimes misplaced, concern that certain activities would be detrimental to the welfare of the handicapped person as well as to others. *See, e.g., Upshur v. Love*, 474 F. Supp. 332 (N.D.Cal. 1979) (consideration of problems which would be faced by a blind school administrator); *Pushkin v. Regents of the University of Colorado)*, 658 F.2d 1372, 1387-90 (10th Cir. 1981) (consideration of problems which would be faced by psychiatric resident with multiple sclerosis).

The United States Court of Appeals for the Tenth Circuit aptly summarized the irrelevance of the discriminatory intent standard to the handicapped in *Pushkin, supra*, 658 F.2d at 1385, as follows:

> Defendants are creating a straw man and thereafter destroying it. It would be a rare case indeed in which a hostile discriminatory purpose or subjective intent to discriminate solely on the basis of handicap could be shown. Discrimination on the basis of handicap usually results from more invidious causative elements and often occurs under the guise of extending a helping hand or a mistaken restrictive belief as to the limitations of handicapped persons.

See also New Mexico Ass'n for Retarded Citizens v. New Mexico, 678 F.2d 847, 854 (10th Cir. 1982).[4] In short, a discriminatory intent standard is virtually impossible to apply in the handicapped context because of the difficulty of differentiating invidious animus and benign sympathies, or over-application of stereotypical assumptions, in analyzing the motivation behind any particular decision.

B. DISPARATE IMPACT IS A MEANINGFUL STANDARD IN REGARD TO THE HANDICAPPED

While a discriminatory intent standard is not generally relevant to the handicapped, a disparate impact[5] standard is uniquely

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[4] After noting the total inapplicability of a discriminatory intent (or "disparate treatment") standard in *Pushkin*, and that claims under § 504 "would be analyzed more readily under a disparate impact" approach, the Tenth Circuit held that, in the context of an employment discrimination claim of an individual plaintiff, § 504 sets its own statutory criteria for scrutinizing such claims. Assuming *arguendo* the validity of the Tenth Circuits's approach in regard to individual employment discrimination claims, the specific statutory language does not precisely address the diverse, complex circumstances raised in pattern and practice employment discrimination suits or to other discrimination claims outside the employment context. *See McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 802 n.14 (1973); *Texas Dep't. of Community Affairs v. Burdine*, 450 U.S. 248, 252 n.5 (1981) (different burden of proof standards applied under Title VII to individual cases and pattern and practice cases). The brief *amicus curiae* of the Equal Employment Advisory Council overlooks these important distinctions.

[5] The terms "discriminatory impact" and "disparate impact" tend to be used interchangeably in the cases and commentaries, and similarly will be used (cont.)

responsive to the two major distinguishing characteristics of discrimination in this context. The first such characteristic is the difficulty of defining a coherent group of the handicapped. Unlike racial minorities (or victims of gender or age discrimination), the handicapped do not constitute an easily identifiable group sharing common physical, psychological, or cultural characteristics. Rather, the "handicapped" constitute a range of persons exhibiting such diverse disabilities such as blindness, cerebral palsy, and emotional disturbances. *See* J. tenBroek and F. Mattson, *The Disabled and the Law of Welfare*, 54 Cal. L. Rev. 809, 811 (1966); Gittler, *Fair Employment and the Handicapped: A Legal Perspective*, 27 DePaul L. Rev. 953, 972 (1978).[6]

The concept of disparate impact is precisely tailored to deal with such definitional complexities. A focus on impact allows a decision maker to assess the extent to which the challenged action affects some or all of the subgroups that constitute the handicapped, and the seriousness of both the relative and the overall injury. Such an assessment can only be done in the grounded, factual context of an impact analysis.

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interchangeably in this brief. The concept has been succinctly defined as follows:

"The disparate impact theory of discrimination provides that facially neutral practices which have an adverse impact on the opportunities of members of a protected class are illegal irrespective of any specific intent to create that impact, unless the practice is mandated by business necessity or has a manifest relationship to some legitimate interest of the defendant." Belton, *Burdens of Pleading and Proof in Discrimination Cases: Toward a New Theory of Procedural Justice*, 34 Vand. L. Rev. 1205, 1209, n.14 (1981).

[6] For these reasons, the difficulties in defining the applicable class of the "handicapped" discussed in the dissenting opinion below, 715 F.2d 1036, 1047-8, are not unique to this case, but apply generally to virtually any attempt to apply the general definition of the term "handicapped individual" as set forth in 29 U.S.C. § 706(7)(B); 34 C.F.R. § 104.3(j)(2) and 45 C.F.R. § 84.3(j)(2) to a specific factual context. However, the Court need not consider these specific definitional issues in this case since, as the Sixth Circuit found below, the extent of disparate impact involved here was sufficiently substantial to preclude the need for a fine-tuned definitional analysis and, in any event, the defendants had specifically conceded a disproportionate impact upon the "handicapped population of Medicaid recipients..." 715 F.2d at 1042, n.7.

The second major characteristic is that "handicapping conditions" are, to some extent, socially defined, rather than absolute criteria. Many disabilities exist, in whole or in part, only in relation to arbitrarily established physical barriers, sorting standards, or other societally imposed classifications or limitations. *See*,, F. Bowe, *Handicapping America: Barriers to Disabled People* (1978); J. Gliedman and W. Roth, *The Unexpected Minority: Handicapped Children in America* (1980); S. Sarason and J. Doris, *Educational Handicap, Public Policy and Social History* (1979); United States Commission On Civil Rights, *supra* at 5-10. On the other hand, it must also be noted that the very notion of "handicap" implies limitations which may, at times, justify decisions to exclude a disabled person from participation in certain programs or activities.

Thus, the need to weigh, in each particular factual context, the extent to which a particular aggrievement results from unreasonable social or physical restrictions, on the one hand, or from limitations inherent to the disabling condition that cannot reasonably be overcome, on the other, calls for the type of judicial scrutiny invoked upon a disparate impact analysis. Through such an analysis the decisionmaker can consider the financial, political and administrative costs of possible alternatives and decide whether a "reasonable accommodation" to the needs of the handicapped has been undertaken. Where warranted, a precise remedy, appropriate to the particular circumstances, can only be formulated through such a process. In short, prohibiting "discrimination" against the handicapped, in practice, often means ensuring that policies or practices which have a detrimental effect on the handicapped were not carelessly or callously imposed. An impact standard is the flexible, feasible approach for making such judgments.

The key provisions of § 504, in essence, provide analytic parameters that require government officials responsible for policies or practices which have a disparate impact on the handicapped to "substantially justify" their actions. Thus, the mandate that "no otherwise qualified handicapped person" shall be discriminated against "solely on the basis of his handicap" requires a court in practice to assess the impact of an exclusionary

practice on individuals or groups who claim to be handicapped and to determine whether any disparate impact which may exist may be justifiable. See Wegner, *The Anti-Discrimination Model Reconsidered: Ensuring Equal Opportunity Without Respect to Handicaps Under Section 504 of the Rehabilitation Act of 1973*, 60 Cornell L.Rev. 403, 433-434 (1984).

As this Court's detailed analysis of the claims of the applicant to the nursing degree program in *Southeastern Community College v. Davis*, 442 U.S. 397 (1979) made clear, questions of qualification cannot be separated, in the context of the rights of the handicapped, from the issue of the extent to which a defendant has an obligation to provide modifications or "reasonable accommodations" to a federally funded program. While rejecting a reading of § 504 or the HEW regulations that would impose extensive affirmative action requirements fundamentally altering the program involved, or undue administrative burdens, the Court explicitly recognized in *Southeastern* that "situations may arise where a refusal to modify an existing program might become unreasonable and discriminatory." 422 U.S. at 412-413.

Southeastern makes clear, therefore, that as applied to the handicapped, the concept of discrimination is contextual. It requires a careful balancing of a) the qualifications and/or needs of the handicapped person or persons affected, b) the purposes of the program at issue, and c) the reasonableness of any attempts to accommodate the qualifications and needs of the handicapped in that context. *See Majors v. Housing Authority*, 652 F.2d 454 (5th Cir. 1981) (case removed for trial on key § 504 elements, despite agreed stipulation of fact on these issues). In the first instance, such contextual balancing is the responsibility of the relevant federal administrative agencies. *Southeastern* at 413. Where the agency has issued specific regulations that precisely govern the application of § 504 to the particular context, clearly the courts should defer to the expertise of the agency and apply its standards. *See, e.g., Rhode Island Handicapped Action Committee v. Rhode Island Public Transit Authority*, 718 F.2d 490 (1st Cir. 1983) (Department of Transportation regulations calling for application of 3.5% of federal funds to

the needs of the handicapped held to satisfy "special efforts" requirements of Urban Mass Transit Act and program modification requirements of § 504). However, where, as here, the applicable federal regulations are not specific enough to resolve the particular factual issues, the requisite review of the "reasonable accommodation" of challenged state actions must be undertaken by the courts. *Shirey v. DeVine*, 670 F.2d 1188, 1198 (D.C. Cir. 1982).

In essence, then, in the § 504 context, a "disparate impact" standard can be viewed as a shorthand phrase to describe the appropriate steps that are required under *Southeastern*, in cases where there are no concrete administrative regulations covering the specific fact pattern involved. Invocation of the disparate impact standard provides a mechanism for courts to ensure that state officials have adequately considered the needs of the handicapped before taking actions which negatively affect them. Unlike an affirmative action requirement, disparate impact does not require a governmental agency to undo the affects of past discrimination;[7] it merely requires courts to inquire into the possible "thoughtlessness" of some official policies or practices. *Hobson v. Hanson*, 269 F. Supp. 401, 497 (D.D.C. 1967), *aff'd sub nom. Smuck v. Hobson*, 408 F.2d 175 (D.C. Cir. 1969).

C. APPLICATION OF A DISPARATE IMPACT STANDARD IS CONSISTENT WITH THE LEGISLATIVE HISTORY OF § 504

Petitioners argue in Point I of their brief that Congress intended only to prohibit intentional discrimination under § 504. This conclusion is not based on any substantive analysis of Congressional debates or Committee reports.[8] Rather it is built from

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[7] Where, however, Congress has specifically provided for affirmative action requirements, as in 29 U.S.C. §§ 791, 793, it has called for remedies which go beyond disparate impact/substantial justification requirements.

[8] "There is almost no substantive legislative history surrounding the development and enactment of § 504. There were, for example, no public hearings accompanying the original bills and there was almost no substantial floor (cont.)

inference based on this Court's treatment of the legislative intent behind the analogous provisions of Title VI of the 1964 Civil Rights Act in *Regents of the University of California v. Bakke*, 438 U.S. 265 (1978) and *Guardians Association v. Civil Service Commission*, 103 S.Ct. 3221 (1983).

Certainly, it cannot be denied that § 504 "was patterned after Title VI of the Civil Rights Act of 1964..." *Community Television v Godfried*, 103 S.Ct. 885, 892 (1983); *Consolidated Rail Corporation v. Darrone*, 104 S.Ct. 1248, 1255 (1984).[9] However, although Congress clearly intended to extend the anti-discrimination mandate of Title VI to cover this additional

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debate." Statement of Department of HEW, 41 Fed. Reg. 20296 (proposed May 17, 1976). *See, e.g.*, S.Rep.No. 318, 93d, Cong., 1st Sess. (1973), *reprinted in* 1973 U.S. Code Cong. & Ad. News 2076. Although the 1974 amendments expanded the definition of handicapped individuals applicable to § 504 (§ 111(a) of the Rehabilitation Act Amendments of 1974 (Pub. L. No. 93-516)) and 1978 amendments added § 505 to the Act specifying that the remedies, procedures and rights under Title VI should apply to cases brought under § 504 (Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978, Pub. L. No. 95-602, § 120(a), 92 Stat. 2982 (1978) (codified at 29 U.S.C. § 794(a)(2)), there is litle explicit discussion of the meaning of the concept of discrimination available in the legislative debate or committee reports on the amendments. *See* S. Rep. No. 1297 (93d Cong., 2d Sess., *reprinted in* 1974 U.S. Code Cong. & Ad. News 6373, 6388-6390. *See* generally, Note, *Accommodating the Handicapped: The Meaning of Discrimination Under Section 504 After* Southeastern, 80 Colum. L. Rev. 171, 172-176 (1980); Note, *Accommodating the Handicapped: The Meaning of Discrimination Under Section 504 of the Rehabilitation Act*, 55 N.Y.U. L. Rev. 881, 888-894 (1980).

[9] Section 504 had its origins in unsuccessful attempts by members of Congress to include the handicapped among those explicitly included in the protections of Title VI. S.3044, 92d, Cong., 2d Sess. 118 Cong. Rec. 525 (1972); H.R. 12154, 92d Cong., 1st. Sess. 117 Cong. Rec. 45, 945 (1971). The provisions of § 504 were originally introduced in their present form as part of the Rehabilitation Act of 1972. S.3987, 92d Cong., 2d Sess. 118 Cong. Rec. 30680 (1972). The Rehabilitation Act was a broad statute designed to enable handicapped persons to enhance their productive capability, foster self-sufficiency and independence, and integrate them into the work force by providing such services as rehabilitation counseling, physical and mental restoration services, (cont.)

group, it also was well aware of the distinctive characteristics of the handicapped.[10] Given the scantiness of the legislative history of § 504, the statute must be read in the context of its general "history and purposes," *Darrone*, *supra* at 1254, n.13, and this means that, as with the "primary objective" limitation involved in *Darrone*, Congress must be presumed to have had an intention to endorse the approach that makes most sense in the particular context in regard to the intent/impact distinction at the core of the present case. Congress cannot be presumed to have intended to adopt an "intent" standard that had little relevance to the actual problems it sought to correct.[11]

(cont.)
transportation and technological aids. *See* S.3987, 92d Cong. 2d Sess. 118 Cong. Rec. 30680 (1972) and S.7, 93d Cong., 1st Sess. 119 Cong. Rec. 156 (1973).

After its enactment by Congress, however, the 1972 Act was vetoed by President Nixon for the stated reason that this wide variety of new programs would be too costly. "Memorandum of Disapproval of Nine Bills," Pub. Papers: Richard M. Nixon, pp. 1042, 1045 (Oct. 27, 1972); "Veto of the Vocational Rehabilitation Bill," Pub. Papers: Richard M. Nixon, p. 223 (March 27, 1973). The Act was reintroduced the next year as the Rehabilitation Act of 1973 with § 504 again as one of its provisions. S.1875, 93d Cong., 1st Sess. 119 Cong. Rec. 16, 665 (1973); H.R. 8070, 93d Cong., 1st Sess. 119 Cong. Rec. 18116 (1973). The final version of the bill, which was adopted by Congress and signed into law in September 1973, was a compromise which reduced funding levels, gave equal (but not priority) service to the severely handicapped, and eliminated several proposed new programs. However, the civil rights provisions of § 504 remained untouched.

[10] *See, e.g.*, S. Rep. No. 1297, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. Code Cong. & Ad. News 6373, 6389 (noting that the discrimination suffered by individuals simply by being classified or lableled, correctly or incorrectly, as handicapped "has no direct parallel in either race or sex discrimination."); 124 Cong. Rec. 30, 578 (1978) (statement of Sen. Cranston) (barriers facing handicapped individuals are both attitudinal and physical); 118 Cong. Rec. 525 (1972) (statement of Sen. Humphrey) (discussing explanations for exclusions of handicapped children from educational opportunities, including problems of transportation and architectural barriers.) *See also*, Statement of Dept. of HEW, 42 Fed. Reg. 22676 (1977) (the problem of ending discrimination on the basis of handicap is extremely complex "in part because of the 'diversity of types of handicap.' "

[11] The fact that "[a]t least 24 federal agencies have regulations which incorporate a 'disparate impact' test" (Brief of the United States as *amicus curiae*, p. 1, n.2) further exemplifies the inappropriateness of an intent standard in this context.

This Court held in interpreting analogous provisions of Title IX of the Education Amendments of 1972, "It is Congress' intention in 1972, not in 1964, that is of significance..." *North Haven Board of Education v. Bell*, 456 U.S. 512, 529 (1982). The fact that § 504 was adopted nine years after passage of Title VI, at a time when Congress was aware that Title VI was broadly being implemented by the federal administrative agencies through an impact standard (*see New York State Ass'n for Retarded Children v. Carey*, 612 F.2d 644, 649 n. 5 (2d Cir. 1979), means that the drafters of the Rehabilitation Act could have reasonably assumed that the broad anti-discrimination language they were borrowing from Title VI was relevent to this context and could be applied through a disparate impact standard that would assure protection for the handicapped.

The Court's interpretation of analogous provisions of Title VI in *Bakke*, *supra*, and *Guardians*, *supra*, does not require an inappropriate "intent" reading of § 504. In *Bakke*, a majority of this Court held that Congress in Title VI intended to incorporate the Constitutional anti-discrimination standard, and that "the meaning of the statute's prohibition [would] evolve with the interpretation of the commands of the Constitution." 438 U.S. at 340. (Opinion of Brennan, White, Marshall, and Blackmun, J.J.). In *Guardians*, seven members of the Court held that, following *Bakke*, the constitutional requirement for a showing of discriminatory intent articulated in *Washington v. Davis*, *supra*, must be deemed to be incorporated as the statutory intent of Title VI. (At the same time, however, a different majority held that regulations adopted by the administrative agencies enforcing Title VI, which incorporated a discriminatory impact standard should, nevertheless, be deemed valid and enforceable.)

Petitioners' assumption that the *Guardians* precedent compels an "intent" reading of § 504 overlooks both the separate historical context of the passage of § 504, discussed above, and the inapplicability of the Constitutional incorporation doctrine to § 504. In its consideration of the 1964 Civil Rights Act, Congress was keenly aware of the desegregation mandates of *Brown v. Board of Education*, 347 U.S. 483 (1954) and its progency;

in that context, the stated intent of Title VI was to aid in the enforcement of the Constitutional requirements. By way of contrast, at the time of the passage of the Rehabilitation Act in 1973, there was no history of problems of enforcement of Constitutional mandates in regard to the handicapped. On the contrary, there were, at that time, no clearly articulated constitutional standards for defining discrimination against handicapped persons.

Moreover, assuming *arguendo* that Congress meant to incorporate a constitutional standard into § 504, there is no basis for assuming that the appropriate constitutional equal protection standard would necessarily be the *Washington v. Davis* discriminatory intent standard applied by the Court in the race discrimination context. To date, this Court has specifically declined to rule on the issue of the appropriate constitutional standard to be applied to equal protection claims of the handicapped. *Schweiker v. Wilson*, 450 U.S. 221, 231 (1981).[12] Petitioners' approach, however, would require the Court to reach this constitutional issue, directly or by implication.

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[12] Most of the lower courts which have considered the matter have held that the constitutional standard in cases involving rights of the handicapped should be a "middle ground" equal protection test which would require a showing of a "substantial justification" for legislative enactments which had a detrimental effect on the handicapped. *See e.g., Cleburne Living Center v. City of Cleburne*,726 F. 2d 191 (5th Cir. 1984); *J.W. v. City of Tacoma*, 720 F.2d 1126 (9th Cir. 1983); *Sterling v. Harris*, 478 F.Supp. 1046 (N.D.Ill. 1979), *rev'd on other grounds sub nom. Schweiker v. Wilson, supra; Association for Retarded Citizens v. Olsen*, 561 F.Supp 473, 490 (D.N.D. 1982); *Frederick L. v. Thomas*, 408 F. Supp. 832, 836 (E.D.Pa. 1976); *Garrity v. Gallen, supra*, 522 F.Supp. at 236-237; *LORA v. Board of Education*, 456 F.Supp. 1211, 1275 (E.D.N.Y. 1978); *cf., e.g., Massachusetts Coalition of Citizens with Disabilities v. Civil Defense Agency*, 649 F.2d 71 (1st Cir. 1981); *Fialkowski v. Shapp*, 405 F. Supp. 946 (E.D.Pa. 1975) (cases discussing applicability of strict scrutiny standard to handicapped), and

Finally, assuming *arguendo* that petitioners' position concerning the dispositive applicability of *Guardians* is correct, the Sixth Circuit's decision in this case still should be affirmed on the basis of the distinction accepted by at least four members of this Court in *Guardians* that an impact standard may be upheld in order to enforce the applicable federal agency regulations rather than the statute itself. The regulations applicable to this situation clearly prescribe an "effects" test calling for a disparate impact standard.[13] Petitioners' argument that giving force to these regulations would not be "reasonably related to the purposes of the enabling legislation," *Guardians*, *supra*, 103

(cont.)
Burgdorf & Burgdorf, *The Qualifications of Handicapped Persons as a "Suspect Class" Under the Equal Protection Clause*, 15 Santa Clara L. Rev. 855 (1975).

Such a "middle ground" constitutional standard is analogous to the "substantial justification" burden of proof requirement implicit in disparate impact analysis. Its wide acceptability by the lower courts as a constitiutional standard for discrimination against the handiapped, therefore, is a further indication of the appropriateness of a disparate impact standard in this context.

[13] 45 C.F.R. § 84.4(b)(4), applicable to state agencies receiving Medicaid funds, provides that:

"A recipient may not, directly or through contractual or other arrangements, utilize criteria or methods of administration (i) that have the *effect* of subjecting qualified handicapped persons to discrimination on the basis of handicap, (ii) that have the *purpose or effect* of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect ot handdicapped persons, or (iii) that perpetuate the discrimination of another recipient if both recipients are subject to common administrative control or are agencies of the same state." (emphasis added) *See also* 45 C.F.R. § 84.52(a).

Petitioners, at page 13 of their brief, emphasize the "equality of opportunity/equality of result provisions of 45 C.F.R. § 84.4(b)(2), and imply that an impact standard is synonymous with the discredited "equality of result" approach. As argued above, however, there is no basis for making such an equation and the drafters of the regulation explicitly noted that use of the equality of opportunity/equality of result terminology in the handicapped context had different connotations than in the racial context. *See*, Statement of Department of HEW, 41 Fed. Reg. 20296 (1976) ("[H]andicapped persons may require different treatment in order to be afforded equal access to federally assisted programs and activitites, and identical treatment may, in fact, constitute discrimination.")

S.Ct. at 3254 (Stevens, J., dissenting) (citations omitted) is untenable. An "intent" reading of § 504, if not totally unwarranted, as argued elsewhere in this brief, is, at the least, no more inconsistent with application of "impact" regulations than was the decision to enforce the regulations in *Guardians* in the face of a specific "intent" reading of Title VI by seven members of the Court.[14] Moreover, given the complexities of determining and remedying discrimination in the handicapped context, the concrete experience of the administrative agencies and their specific regulations take on added significance.

POINT II

THE COURT BELOW CORRECTLY APPLIED THE DISPARATE IMPACT STANDARD TO THE FACTS OF THIS CASE

Petitioners claim that even if a disparate impact standard is appropriate for applying § 504, the Court of Appeals' decision here should be reversed because plaintiffs suffered no such impact. This argument is premised on an assumption that "equal access to 14 in-patient hospital days per year" is all that § 504 demands in the present circumstances" (Petitioners' Brief at 21) and that plaintiffs' position amounts to an unreasonable requirement that every governmental program "ensure equal efficiency." *Id.* at 24. The brief of the United States as *amicus curiae* analyzes in greater depth the inapplicability of the "equality of results" approach by which it characterizes the decision of the Court below. (Brief of the United States as *amicus curiae* at 21-22.)

The position of the petitioners and the Justice Department is fundamentally flawed, however, because it is based upon an artificial dichotomy between equality of access and equality of results which has no relevance to the handicapped context and does not provide a meaningful framework for considering the

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[14] Unlike the situation in *Southeastern Community College v. Davis*, *supra*, 442 U.S. at 411, the applicable regulations here are not being interpreted to impose a specific "affirmative action obligation on all recipients of federal funds," which might be deemed inconsistent with the statutory intent.

Court of Appeals' actual decision in this case.[18] Nowhere in the Court of Appeals' decision is there mention of plaintiffs' right to receive "equal results," "equal efficiency" or a full satisfaction of their health needs. Instead, the Court speaks of the need to give some reasonable consideration to alternative means that, it is claimed, could better meet the needs of the handicapped, without breaching the state's budget ceiling or unreasonably affecting other groups and individuals.

Specifically, the Sixth Circuit reversed and remanded the District Court's decision because "the plaintiffs proved a *prima facie* case of discrimination against the handicapped and purported

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[18] The difficulties of applying the equality of opportunity/equality of result dichotomy to the handicapped context are clearly reflected in the United States' *amicus curiae* brief. The argument there at first appears to adopt the simplistic position that the appropriate standard should be "equal shares" or "equal access," so that the mandate of § 504 would be met if the handicapped are given the same dollar value of services as the non-handicapped (Brief of the United States as *amicus curiae* at 13) or, applied to this case, an equal number of days in the hospital (*id.* at 17, 18). Later, however, the government admits by reference to examples such as the necessity for providing ramps to permit meaningful access to school or libraries that, at times, additional resources must be expended to render "access" or "opportunity" meaningful for the handicapped. (*id* at 27.)

The analysis concludes with a "fox and stork" example which purports to summarize the entire issue by stating that "if an equal amount of milk is offered in a container accessible to both, there is no discrimination under Section 504, even though the fox, in order to be healthy, needs more milk than the stork." (*Id.* at 28.) But this fable omits, in its simplicity, a number of key factors that a real world § 504 decisionmaker would need to know: What is the purpose behind the milk distribution program? Is the amount of milk being given to the stork grossly in excess of his reasonable needs? Is the additional amount required by the fox small or large? Does the additional increment constitute a life or death difference for the fox?

Reasonable application of § 504 clearly requires consideration of these questions in the particular factual setting; abstract access/result formulations cannot answer them. Under certain circumstances, handicapped plaintiffs might reasonably be entitled to a minimum level of benefits, even if their needs required greater *per capita* resource allocations. (*See, e.g., Board of Education v. Rowley, supra; Georgia Ass'n of Retarded Citizens v. McDaniel*, 716 F.2d 1565 (11th Cir. 1983).) In other circumstances, such allocations might be held to be unreasonable. *See, e.g., American Public Transit Ass'n v. Lewis*, 655 F.2d 1272 (D.C. Cir. 1981).

to present an alternative which has a less discriminatory impact and would meet the State's need to save money." 715 F.2d at 1044. The record further indicated that the plaintiffs' alternative which, purportedly, would fully provide the requisite cost savings to the State, but with lesser impact on the class of handicapped patients, had never even been considered as an option by the State officials. *Id.* at 1044-45.[16] The Court's specific remand directive was that:

> The State should be required to provide a substantial justification for its choice of a reduction in inpatient hospital days when equal savings could be achieved by limiting the number of admissions covered by Medicaid...The State could also meet its burden by proving that a limit on the number of admissions will not yield the same amount of cost savings achieved by the State's per day restriction. *Id.* at 1046 (citations omitted).[17]

Under the circumstances, the Court of Appeals' remand decision amounts, in essence, to a requirement that the state "explain its choice." *Id.* at 1044. Surely, given the State's responsibility under § 504 to insure that programs supported by federal funding permit reasonable participation by the handicapped, this is the minimal burden that reasonably could be imposed upon the defendants. Indeed, in light of the life-sustaining nature of the benefit at issue, the state's refusal to undertake

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[16] Plaintiffs' claim that their alternate approach would not require greater overall spending by the State for its Medicaid program distinguishes this case from *Doe v. Colautti*, 592 F.2d 704 (3d Cir. 1979) and *Doe v. Devine*, 545 F.Supp. 576 (D.D.C. 1982), *aff'd on other grounds*, 703 F.2d 1319 (D.C. Cir. 1983). In both of these hospital cost cases, plaintiffs sought increased benefits for the mentally ill which would have substantially increased the defendants' overall costs; on the particular facts of those cases, the courts ruled that the cost containment measures were reasonable.

[17] Since plaintiffs had put forward an alternative cost saving measure based on a limit on the length of each hospital stay (Petitioner's Appendix A59-A61), it is not clear whether the Court of Appeals misconstrued plaintiffs' alternative or meant to put forward an additional alternative when it spoke of a "limit on the number of admissions."

such minimal consideration of known alternatives in use in other states (Pet. App. A158-A166) was astounding.

In formulating its remedial order, the Court below referred to two previous cases in which a disparate impact standard had been applied in the context of claims of racial discrimination under Title VI to medical cost cutback situations, *Bryan v. Koch*, 627 F.2d 612 (2d Cir. 1980) and *NAACP v. Medical Center, Inc.*, 657 F.2d 1322 (3d Cir. 1981). In *Bryan*, the majority specifically considered, and rejected, the more demanding standard adopted by the courts in Title VII cases which would require an employer, upon a showing of a disparate impact, to establish compelling reasons of "business necessity" for rejecting an available alternative selection method with lesser disparate impact. *See, e.g., Blake v. City of Los Angeles*, 595 F.2d 1367, 1376 (9th Cir. 1979); *cert. denied*, 446 U.S. 928 (1980); *Robinson v. Lorilland Corp.*, 444 F.2d 791, 798 (4th Cir. 1971); *cf. Albemarle Paper Co. v. Moody*, 422 U.S. 405, 425 (1975).[18] Instead, the Court in *Bryan* held that in Title VI cases, it would call upon the government agency only to show that it had engaged in a reasonable policy making process which involved consideration of any clear alternatives which might have "obvious advantages"; the Court specifically eschewed a standard which would require a defendant to show that it had considered every possible alternative, since this would draw the courts into a "complex inquiry...[concerning] the wisdom of competing political and economic alternatives" 627 F.2d at 619.[19]

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[18] An even more stringent burden of showing "that no alternative course of action could be adopted" has been applied by courts in cases raising claims of housing discrimination under Title VIII of the 1968 Civil Rights Act. *See, e.g., Resident Advisory Board v. Rizzo*, 564 F.2d 126, 149 (3d Cir. 1977), *cert. denied*, 435 U.S. 908 (1978)).

[19] Judge Kearse's separate decision, concurring in part and dissenting in part, emphasized that in a Title VI context, the appropriate approach should be to first consider the rationality of the decision making process; and a "rational process must include consideration of appropriate alternatives in the light of a factual assessment of the effect of these alternatives." 627 F.2d at 623. She would hold in *Bryan* that the city had taken an unreasonably narrow view of the range of available alternatives and that the record showed a lack of sufficient information as to actual effects of the alternatives considered on the hospital patients involved. 627 F.2d at 624.

In *Medical Center*, the District Court had placed upon defendants a burden of showing that they had considered all possible less discriminatory alternatives and that no alternative with lesser disparate impact existed which would meet the defendants' legitimate aims. Sitting *en banc*, the Third Circuit agreed that defendants in the case at hand had met this heavy burden, but indicated that the District Court's approach was more stringent than Title VI required, since the plaintiffs should retain the burden of persuasion on the existence of feasible, less discriminatory, alternatives. 657 F.2d at 1336.[20]

The Sixth Circuit in the present case has fashioned a remedial approach for § 504 cases which is consistent with the moderate approach adopted by the majority opinions in *Bryan* and *Medical Center* in the Title VI context. Specifically the Court here:

a) Imposed an initial burden on plaintiffs to establish a *prima facie* case of discriminatory impact;

b) Then shifted the burden to defendants to show that the "decision making process was a rational one," 715 F.2d at 1044, "by coming forward with some substantial justification" for the plan it adopted. 715 F.2d at 1045.

c) To establish a substantial justification, defendants were not required to show that they had carefully considered all possible alternatives, or even all alternatives with "obvious advantages"; instead they were required to consider only plaintiffs' specific alternative plan which, it had been alleged, could accomplish the state's legitimate ends with lesser disparate impact at the same cost.

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[20] Justice Gibbons dissented on this point stating that:

"[S]ince in many cases the means of proof of justification will not be within the reach of the protected class and allocations of the burden of persuasion will be dispositive, the only allocation consistent with the Congressional intention to protect the disadvantaged class from actions showing discriminatory effects is to assign the burden of justifying the impact to the defendant who received federal funds." 657 F.2d at 1352. Justices Higgenbotham and Sloviter also endorsed the standard used by the District Court. 657 F.2d at 1337, n. 18.

d) In considering plaintiffs' alternative, the State would be required only to show either that (1) plaintiffs' plan is not a feasible, cost-saving alternative or (2) that the state's plan is superior for other reasons, despite its disparate effects. 715 F.2d at 1045.[21]

In essence, then, the court below merely imposed upon the state defendants a burden of providing a "substantial justification"[22] for its 14-day annual limit policy, in light of plaintiff's purported superior alternative plan. The manner in which the record developed in this case permitted the court here actually to impose a lesser burden than even the moderate approach of *Bryan* and *Medical Center*, since the present defendants have not been required to consider a range of alternatives; they merely are being asked to show that they have considered the possible advantages of the one specific alternative put forward by plaintiffs. This approach places a minimal burden on the state defendants to show that some reasonable consideration has been given to the needs of the handicapped population in a setting where cutbacks have had a severe disparate impact on their well-being.[23]

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[21] Presumably, if the state comes forward with evidence on either of these points, the plaintiffs will retain an ultimate burden of persuasion on the existence of a feasible, less discriminatory alternative. *See Texas Dep't. of Community Affairs v. Burdine*, 450 U.S. 248 (1981).

[22] The Sixth Circuit's "substantial justification" concept apparently was borrowed from the similar criterion utilized by this Court in cases applying the "middle ground" equal protection analysis. It therefore implies that state actions which have a disparate impact on the handicapped "must serve important governmental objectives and must be substantially related to achievement of those objectives. . ." *Craig v. Boren*, 429 U.S. 190, 197 (1976). A variety of factors enter into a substantial justification analysis, such as relative costs, efficacy, burdens on public services, and extent of plaintiffs' needs (*see, e.g., Plyler v. Doe*, 457 U.S. 202 (1982), and the precise weight to be given to each must necessarily depend on the specific circumstances. It is clear, however, that defendants' only seeming justifications for its refusal to even consider any alternative in this case, "administrative ease and convenience," standing alone, are not "sufficiently important objectives" to permit a disparate impact on a protected class. *Craig, supra* at 198.

[23] Following this Court's decision in *Southeastern Community College, supra*, a number of the lower federal courts have articulated a two-fold standard (cont.)

Given the modest nature of the remand order in this case, Judge Merritt's claim that under this approach, "plaintiff always wins" is clearly hyperbole. Plaintiffs will win in this case only if they establish on remand that their alternative approach is both feasible and cost-efficient.[24] Whether they will indeed meet that burden is yet to be seen. From *amicus'* point of view, the critical consideration is that the present defendants, as well as all other public officials, be made aware of their responsibility under § 504 reasonably to consider the impact of proposed policies and actions on the handicapped and to provide a substantial justification, in light of all the facts of the particular circumstances, for such actions.

(cont.)
for applying the reasonable accommodation requirements of § 504 to a variety of factual situations: 1) does the requested relief substantially interfere with existing program services; and 2) do such modifications place an undue financial and administrative burden on the defendant? *See, e.g., Turillo v. Tyson*, 535 F.Supp. 577 (D.R.I. 1982); *New Mexico Ass'n for Retarded Citizens*, 678 F.2d at 855; *Strathie v. Department of Transportation*, 716 F.2d 227, 231 (3d Cir. 1983); *see also* Note, *Accommodating the Handicapped: The Meaning of Discrimination Under § 504 of the Rehabilitation Act*, 55 N.Y.U. L. Rev. 881, 900-902 (1980). *Cf.* Note, *Employment Discrimination Against the Handicapped and § 504 of the Rehabilitation Act: An Essay on Legal Evasiveness*, 97 Harv. L. Rev. 997, 1012-1014 (1984). The Sixth Circuit's order in this case avoids the difficult cost balancing issues involved in these cases since the court here has indicated that only one alternative approach need be considered and that the precise level of cost savings sought by the State must be realized.

[24] Plaintiffs, in *Bryan* and *Medical Center*, in fact failed to meet the analogous "disparate impact" standards. The plaintiffs also were denied relief under the § 504 "substantial justification" standard applied by the Court to the hospital cost issues involved in *Bernard B. v. Blue Cross/Blue Shield*, 528 F.Supp. 125 (S.D.N.Y. 1981), *aff'd*, 679 F.2d 7 (2d Cir. 1982). *See also, Anderson v. Banks*, 520 F.Supp. 472, 511 (S.D.Ga. 1981).

CONCLUSION

For all the above reasons, the decision of the United States Court of Appeals for the Sixth Circuit should be affirmed.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

LAMAR ALEXANDER, *et al.*,

Petitioners,

v.

HERSHEL CHOATE, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTIONS PRESENTED

1. Does section 504 of the Rehabilitation Act of 1973 forbid practices which have the effect of discriminating by reason of handicap?

2. If section 504 forbids only practices which are motivated by an intent to discriminate against handicapped individuals, are the regulations promulgated by 24 federal agencies forbidding practices with a discriminatory effect nonetheless valid as reasonably related to the statute?

3. Did the limitations imposed by Tennessee in 1980 on its Medicaid hospitalization have a discriminatory effect on the handicapped within the meaning of section 504 and the applicable regulations of the Department of Health and Human Services?

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STATEMENT OF THE CASE

This action was commenced in August, 1980, on behalf of a number of individuals receiving medical care under the Tennessee Medicaid program. Respondents challenged several changes in Medicaid which the State then proposed to institute to reduce the scope and thus the cost of that program. (J.A. 12-15) By the spring of 1981 the parties had settled all issues raised by the complaint except the legality of the state's plan to lower from 20 to 14 days the number of days of hospitalization provided annually to Medicaid patients. (Pet. All). Respondents challenged the legality of that reduction on a number of grounds, of which the only one relevant to

this appeal is a claim that the reduction would violate section 504 of the Rehabilitation Act of 1973.

At trial the state conceded, and the district court therefore assumed without discussion, that section 504 applied to practices which have the effect of discriminating against the handicapped. (Pet. App. A40). The trial court rejected respondents' section 504 claim on two distinct grounds. First, it held that, although respondents had demonstrated that the 14 day rule would have had an adverse impact on handicapped Medicaid patients in 1979-80, respondents had failed to show that the patterns of Medicaid use, and thus the impact of the 14 day rule, would necessarily be the same in future years. (Pet. App. A33-A35). Second, the trial court concluded that the type of adverse impact which existed in 1979-80 was not the

kind of discriminatory effect to which section 504 and the relevant regulations applied. (Pet. App. A35-A43).

On appeal the petitioners again conceded that section 504 applied to practices with a discriminatory effect,[1] and the sixth circuit so held. (Pet. App. A7-A10). The court of appeals concluded that respondents had adequately demonstrated that the 14 day rule would adversely affect handicapped Medicaid patients. (Pet. App. A10-A12). The sixth circuit held that the evidence adduced by respondents was sufficient to establish a prima facie case of unlawful discrimination. (Pet. App. A12-A15, A19 n.12). Since Tennessee had inexplicably failed to adduce at trial any evidence to justify or even explain why it had chosen the 14 day

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[1] Brief for Defendants-Appellees, pp. 11-12.

rule, rather than some method less burdensome for the handicapped, to reduce the scope and cost of the Medicaid program, the court of appeals remanded the case with instructions that the state be afforded another opportunity to do so. (Pet. App. A15-A16).

The state sought certiorari to decide a question which it had never put in issue in the lower courts, whether section 504 and the regulations promulgated pursuant to that statute forbid practices with a discriminatory effect. (Pet. ii, 7). In this Court petitioners now apparently concede that the section 504 regulations establish a discriminatory effect rule, and argue that the regulations are invalid. (Pet. Br. 18). Petitioners also sought certiorari to decide whether the 14 day

rule had an adverse impact within the scope of section 504 and the applicable regulations. (Pet. ii).

SUMMARY OF ARGUMENT

A. Whether section 504 applies to practices with a discriminatory effect cannot be resolved by reference to the statutory language. Other prohibitions against "discrimination" have been construed either to cover such effects, or to apply only to practices motivated by a discriminatory purpose, based on their particular legislative histories. Griggs v. Duke Power Co., 401 U.S. 424 (1971); Guardians Association v. Civil Service Commission, 77 L.Ed.2d 866 (1983).

Section 504 was characterized in broad language by its proponents. Senator Cranston, for example, insisted it dealt "comprehensively" with the problem of

discrimination. (119 Cong. Rec. 5862 (1973)). The term "discrimination" was repeatedly used to describe practices which involved only discriminatory effects, such as architectural barriers, the failure to make accommodations necessary to permit participation by the disabled, and discriminatory employment procedures. None of these practices would be subject to section 504, as Congress clearly intended, if the statute were applied only in cases in which there was proof of a discriminatory motive.

Petitioners suggest that section 504, like Title VI, was intended only to incorporate a constitutional standard regarding discrimination. But in 1973 there were no clearly established constitutional rights concerning discrimination against the handicapped, and none are referred to in the debates on section 504. Although the language of section 504

was patterned after Title VI, in 1973 the unchallenged administrative interpretation of Title VI applied it to practices with a discriminatory effect. "[T]he relevant inquiry is not whether Congress correctly perceived the then state of the law, but what its perception of the law was". Brown v. GSA, 425 U.S. 820, 828 (1976).

Twenty four federal agencies have issued regulations under section 504 which apply it to practices with a discriminatory effect. The section 504 regulations "particularly merit deference" because they were framed in close consultation with Congress. Consolidated Rail Corporation v. Darrone, 79 L.Ed.2d 568, 577 (1984). Several 1978 amendments to the Rehabilitation Act reflect congressional approval of these effect regulations.

B. Even if section 504 itself forbids only practices with a discriminatory purpose, the discriminatory effect regulations are nonetheless valid as reasonably related to the statute. Guardians Association v. Civil Service Commission, 77 L.Ed.2d 866 (1983).

C. The Tennessee Medicaid rules in effect at the time of trial have since been altered. Some individuals who formerly could receive only 14 days of treatment are today eligible for 20 days, while others now get none. Whether the state's present practices have a discriminatory effect, and if so of what type and magnitude, is neither disclosed by the record nor known to the parties. Since plaintiffs seek only injunctive relief, a determination of the legality of the 1980 rules may be inappropriate.

Petitioners have acknowledged that the handicapped population of Medicaid recipients "would suffer proportionally more from the reduction in hospital benefits than the non-handicapped ..." (Pet. App. A11 n.7) Under the 1980 rules 27.4% of handicapped patients were denied needed hospitalization each fiscal year, compared to only 7.8% of nonhandicapped patients. Prior to the 1980 rules, handicapped patients were 33% of these receiving hospitalization under Medicaid, but they were 63.4% of the patients selected to bear the burden of the Medicaid cuts. This type of adverse impact is clearly within the scope of section 504 and the applicable HHS regulations. 45 C.F.R. §§ 84.4(b)(4), 84.52(a)(3).

Tennessee is free to limit the scope of its Medicaid program, and may use any method which does not place the burden of those limitations to a disproportionate

degree on disabled Medicaid patients. Most states control their Medicaid costs by means of practices which have no discriminatory effect. Respondents do not argue that Tennessee should apply to handicapped patients a rule different than that applicable to the nonhandicapped, but ask only that the state adopt a single rule for all which is neutral not only on its face but also in its impact.

The court of appeals did not hold that Tennessee's 14 day rule was unlawful, but concluded only that the undisputed adverse effect established a prima facie case of discrimination under section 504. The sixth circuit directed that on remand the state be afforded an opportunity to justify its selection of the 14 day rule as a method of limiting the Medicaid program. Since Tennessee adduced no evidence at trial to justify or even explain that

choice, its legality cannot be determined on the present record. Neither party sought certiorari to review the legal standards which the sixth circuit announced should be applied on remand to assess any such evidence; the correctness of those standards is therefore not before this Court.

ARGUMENT

I. SECTION 504 PROHIBITS PRACTICES WHICH HAVE THE EFFECT OF DISCRIMINATING AGAINST THE HANDICAPPED

(1) The Statutory Language

Section 504 provides in pertinent part:

> No otherwise qualified individual ... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance....

The term "discrimination", as this Court has repeatedly noted,[2] is susceptible of a variety of interpretations. The "discrimination" forbidden by Title VII has been construed to include practices with a discriminatory effect. Griggs v. Duke Power Co., 401 U.S. 424 (1971). The Title VI prohibition against discrimination, on the other hand, has been held to bar only actions motivated by an invidious purpose. Guardians Association v. Civil Service Commission, 77 L.Ed.2d 866 (1978).

The ambiguous phrase "by reason of" in section 504, like the similar language in Title VI and Title VII,[3] could be read to

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2 Guardians Association v. Civil Service Commission, 77 L.Ed.2d 866, 875 (1983).

3 Title VI refers to exclusion "on the grounds of" race, color or national origin. 42 U.S.C. § 2000d. Title VII forbids the denial of employment opportunities "because of" race, color, religion, sex or national origin. 42 U.S.C. § 2000e-2.

refer to the motives of those administering a federally assisted program, or to the fact that an individual's handicap was the cause of his or her exclusion from participation in or the benefits of such a program. "Reason" can be used to indicate motivation ("the reason for the new policy") or causation ("the reason why the bridge fell down"). The use of the term "solely" prior to "by reason of" in section 504 merely emphasizes that the prohibited basis for exclusion or denial of benefits -- be it motivational or causal -- must be handicap.

The differing interpretations of the similarly vague language of Title VI and Title VII were based on the very different legislative histories of those provisions. Bakke relied on repeated and unequivocal congressional declarations in 1964 that the purpose of Title VI was merely to extend to

programs receiving federal assistance the same then well known constitutional requirements already applicable to programs operated by the federal government.[4] By 1964, it was apparent that the Fifth and Fourteenth Amendments forbad public officials from excluding blacks from government programs or from serving them only on a segregated basis. The purpose of Title VI was to extend to federally assisted activities "the existing right to equal treatment" guaranteed by the Fifth and Fourteenth Amendments. 438 U.S. at 330. In Griggs, on the other hand, this Court noted that Title VII had been enacted in part because of congressional concern that the employment opportunities of minorities and women had been limited by

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[4] 438 U.S. at 287 (Powell, J.), 328 (opinion of Justices Brennan, White, Marshall and Blackmun).

artificial and unnecessary job requirements unrelated to actual qualifications. 401 U.S. at 430-31.

Here, as in Bakke and Griggs, little meaning can be gleaned from the language of section 504 itself. Whether section 504 is to be construed to apply to practices which have the effect of discriminating against the handicapped must be determined in light of the particular legislative history of that provision. "It is Congress' intention in 197[3], not in 1964, that is of significance in interpreting" section 504. North Haven Board of Education v. Bell, 456 U.S. 512, 529 (1982).

(2) The 1972-73 Legislative History

The initial legislative history of section 504 strongly supports a construction which prohibits practices with a discriminatory effect. By 1973 both this Court and EEOC had already construed Title

VII to apply to practices with a discriminatory effect. Griggs v. Duke Power Co., 401 U.S. 424 (1971). Seven federal agencies had issued regulations under Title VI establishing a similar effect standard.[5] Congress had expressly rejected proposals to overturn those Title VI regulations,[6] with opponents arguing that limiting the statute to instances of discriminatory intent "would gut Title VI."[7] Had Congress intended section 504 to be narrowly limited to cases of discriminatory intent, a limitation radically unlike the standard then prevailing in federal civil rights laws, someone surely would have said so, and the members of the House who had

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5 29 Fed. Reg. 16274-16305 (1964).

6 See Guardian Association v. Civil Service Commission, 77 L.Ed.2d 866, 893-94 (1983) (Marshall, J. dissenting).

7 112 Cong. Rec. 18705 (1966) (Rep. Kastenmeier).

opposed such a limitation on Title VI would presumably have voiced a similar objection.

Section 504, on the contrary, was described in expansive terms. Senator Cranston, the acting chairman of the subcommittee that drafted section 504,[8] insisted that section 504 dealt "comprehensively" with the problem of discrimination.[9] Senator Randolph, the Senate manager of the bill, explained that section 504 "prohibits any kind of discrimination against handicapped individuals with respect to any program receiving Federal financial assistance".[10]

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[8] 118 Cong. Rec. 30680 (1972) (Sen. Randolph).

[9] 119 Cong. Rec. 5862 (1973).

[10] 118 Cong. Rec. 30681 (1972). (Emphasis added). The 1974 Senate Report characterized section 504 as establishing "a broad government policy" against discrimination in programs receiving federal assistance. S. Rep. No. 93-1297, 93d Cong., 2d Sess., 38 (1974).

Discussions earlier in the session regarding the problems of the disabled had demonstrated a desire to deal with practices with discriminatory effects. Senator Humphrey, speaking in favor of including the handicapped among the groups protected by Title VI, cited a variety of practices with such effects as falling within the scope of the Title VI language copied into section 504 only a few months later. Among the instances of "discrimination" which Humphrey believed would have been forbideen by such an extension of Title VI were "transportation and architectual barriers", "the discriminatory effect of job qualification ... procedures" and the denial of "special educational assistance" for handicapped children. [11] Senator Williams, the chairman of the Labor and Public Welfare

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[11] 118 Cong. Rec. 525-26 (1972).

Committee which reported out section 504, in a Senate speech only a few months prior to that report also used the term "discrimination" to refer to practices with a discriminatory effect. The handicapped, he asserted, were the victims of "[d]iscrimination in access to public transportation" and "[d]iscrimination because they do not have the simplest forms of special services they need...."[12] Representative Vanik complained that "State governments discriminate by their apathy."[13] Congress recognized, as have the lower courts in applying section 504,[14] that the discrim-

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12 118 Cong. Rec. 3320 (1972); see also id. at 4819 (Sen. Randolph quoting Sen. Williams.)

13 118 Cong. Rec. 2998-99 (1972).

14 See Pushkin v. Regents of University of Colorado, 658 F.2d 1372, 1385 (10th Cir. 1981); NAACP v. Wilmington Medical Center, 491 F. Supp. 290, 317 (D. Del. 1980). There are few reported cases of intentional discriamination against the handicapped. The courts of appeals have generally applied an effects standard in section 504

ination to which the handicapped are subjected is ordinarily the result, not of malice, but of indifference and thoughtlessness.

The obstacles which architectural barriers posed to participation in federally assisted programs, referred to by Senator Humphrey in the passage quoted above, were a recurring concern in the debates on the Vocational Rehabilitation Act of which section 504 was a part, and were repeatedly described in terms of their effects. The 1973 Senate Report noted that such barriers "limit a handicapped indi-

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cases. Dopico v. Goldschmidt, 687 F.2d 644 (2d Cir. 1982); NAACP v. Wilmington Medical Center, 657 F.2d 1322 (3d Cir. 1981)(en banc); Prewitt v. U.S. Postal Service, 662 F.2d 292 (5th Cir. 1981); Jones v. Illinois Dept. of Rehabilitation Services, 689 F.2d 724 (7th Cir. 1982); Pushkin v. Regents of University of Colorado, supra; Stutts v. Freeman, 694 F.2d 666 (11th Cir. 1983).

vidual's ability to function in society."[15] Senator Randolph explained, "Those things that a person without handicaps take[s] for granted--stairs, escalators, narrow doorways--are often insurmountable obstacles to thousands of handicapped individuals."[16] Senators Cranston and Stafford pointed out that such barriers impeded access not only to jobs, but also to the very treatment centers which were supposed to provide services to the disabled.[17] Such barriers certainly had the effect of excluding the disabled from the

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[15] S. Rep. No. 93-318, 93d Cong., 1st Sess., 4 (1973). The 1974 Senate report listed architectural barriers among the forms of discrimination forbidden by section 504. S. Rep. 1297, 93rd Cong. 2d Sess. 50 (1974)

[16] 119 Cong. Rec. 5886 (1973).

[17] 119 Cong. Rec. 5882 (Sen. Cranston), 5893 (Sen. Stafford). See also id at 5898 (Sen. Williams); 117 Cong. Rec. 10311 (1971) (Sen. Dole).

jobs and services available at federally assisted programs, but equally clearly those barriers were the result of indifference, not malice. If, as seems apparent, Congress intended that all such programs were to be accessible to the disabled, that result could only have been achieved if section 504 itself forbad practices with a discriminatory effect.[18]

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[18] Congress hoped to deal with these problems in part through better enforcement of the Architectural Barriers Act of 1968. 82 Stat. 718; 42 U.S.C. §§ 4151, et. seq. But the Architectural Barriers Act covered only buildings constructed or leased with federal funds, and among these applied solely to buildings constructed after the date on which administrative standards of accessibility had been established. Thus, as Representative Vanik emphasized "only the most recently constructed public buildings" were required by law to be accessible to the disabled. 118 Cong. Rec. 2999 (1972). The vast majority of the treatment centers and other federally assisted programs in 1973 were necessarily in buildings which were not subject to the provisions of the Architectural Barriers Act.

Congress's particular concern with the employment problems of the disabled compels a similar conclusion. This Court noted in Consolidated Rail Corporation v. Darrone that "enhancing employment of the handicapped was . . . the focus of the 1973 legislation." 79 L.Ed.2d 568, 575 (1984). Senators Cranston, Williams and Taft[19] noted that the purposes of the multi-billion dollar federal vocational rehabilitation programs were directly defeated by employment discrimination against disabled workers. Congress was anxious to expand employment opportunities for the disabled, not merely out of compassion, but also because such employment would enable the handicapped to become self-supporting individuals and would thus reduce dependence on government assistance programs.

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[19] 119 Cong. Rec. 5882 (Sen. Cranston) 5882 (Sen. Williams), 24587 (Sen. Taft).

Congress realized that in the long term it was considerably less costly to provide a handicapped individual with a job, even if some accommodations were required, than to provide that individual with a lifetime of services and aid at government expense.[20]

Both the federal vocational rehabilitation programs and the repeatedly expressed congressional desire to enable disabled individuals to become productive taxpayers were as frustrated by employment practices with a discriminatory effect as by deliberate employment discrimination. Congress certainly knew, in light of the EEOC regulations and this Court's decision in Griggs, that the employment discrimination forbidden by Title VII included practices with a discriminatory effect. In

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20 118 Cong. Rec. 30680 (Sen. Randolph), 32283 (committee report), 32302 (Sen. Randolph); 119 Cong. Rec. 5886 (Sen. Randolph), 5887 (Sen. Javits), 5893.

the context of employment discrimination against the disabled, a similarly broad construction of section 504 was clearly necessary to achieve the expressed congressional purposes.[21]

Finally, section 504 was intended to assure that federally assisted programs provided services that were reasonably adapted to the need of the handicapped. Senator Cranston argued:

> [T]hose millions of handicapped individuals who pay taxes . . . have the right to expect that their tax money will go toward making . . . their lives and employment easier . . . . For those individuals who have handicapped children, the expenditure of dollars for programs which meet their needs and the needs of

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[21] See also 118 Cong. Rec. 32310 (1972) (Sen. Humphrey) (section 504 will "carry through the intent of ... bills ... introduced ... earlier this year ... to amend ... Title VII ... to make discrimination in employment because of these handicaps, and in the absence of a bona fide occupational qualification, an unlawful employment practice.")

> their children is a simple return on the equity from their taxes which has long since been warranted. 119 Cong. Rec. 5882-83 (1973).

The injustice of which Senator Cranston complained did not concern the motives of program administrators; it was simply unfair, for whatever reason, that disabled individuals who had paid taxes should be offered in return only programs that, while entirely sufficient for others, were inadequate to meet the needs of the handicapped.

Similar concerns regarding government supported programs which adequately served only individuals without disabilities were repeatedly voiced on the floor of both Houses during the debates proceeding the framing of section 504. Senator Williams emphasized that handicapped children needed special assistance if they were to enjoy an equal opportunity to learn, noting that "60

percent of all handicapped children are denied the special services they need to have an equal chance to live freely in this Nation." 118 Cong. Rec. 3320-22 (1972). Senator Dole emphasized that merely providing disabled children with the identical education designed for non-disabled children was often ineffective and unfair.[22] Senator Williams complained that government officials often placed the lowest priority on the problems of the disabled in deciding which programs to fund:

> [S]pecial services and education for the handicapped are the first programs to be done away with during times of economic adversity. The mere fact that services for those who are handicapped are considered frills of government budgets that are cut in times of economic

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22 117 Cong. Rec. 10312 (1971); see also 117 Cong. Rec. 45974 (Rep. Vanik); 118 Cong. Rec. 525 (Sen. Humphrey).

> adversity underlies a tragedy of our society. 118 Cong. Rec. 3320-22 (1972).

The injustices of which Senators Cranston, Dole and Williams spoke concerned, not the motives of the relevant officials, but the failure for whatever reason to provide the disabled with effective services.

A construction of section 504 which limited it to cases of intentional discrimination would lead to a number of incongruous results. If the tables in a school lunch room were so arranged that a student in a wheelchair could not reach the counter at which federally assisted lunches were served, school authorities would have no legal obligation to rearrange the furniture. State officials would be equally free to require applicants for welfare or public housing to personally fill out forms by hand, thus effectively excluding all

blind individuals. Interpreted in this manner section 504 would fall far short of the "comprehensive" solution to the problems of the disabled which its framers clearly intended.

Petitioners, however, suggest that the purpose of section 504, like that of Title VI, was merely to apply to federal grantees the constitutional protections regarding discrimination against the disabled which would be applicable to a government operated program. (Pet. Br. 16). But the debates leading to the enactment of section 504 are very different from those preceeding the adoption of Title VI. The legislative history of section 504, unlike that of Title VI, contains no references to any recognized constitutional standard. The fact that no member of Congress suggested in 1973 that section 504 would extend "the existing rights" of the handicapped to

discrimination by federal grantees is hardly surprising. In 1973 there were no such clearly established constitutional rights. This Court had not then, and has not to this day, decided when handicapped individuals are protected by the constitution from exclusion, intentionally or otherwise, from government programs.

In 1973 Congress could not have known whether any such constitutional protections would subsequently be held to exist. Indeed, petitioners in this Court insist that under the constitution the disabled should enjoy <u>less</u> protection than blacks or hispanics. (Pet. Br. 18 n. 21). Whether in petitioners' view even intentional discrimination against the handicapped would violate the Fifth and Fourteenth Amendments may be an open question. It is difficult to believe that legislation enacted by Congress in 1973 to "deal [] comprehen-

sively with problems such as discrimination in . . . federal grants"[23] was intended merely to extend to federal grantees the substance of future constitutional decisions which would not be issued for years and whose substance no one could then have forseen.

Petitioners argue in the alternative that, since the language of section 504 was patterned after that of Title VI, section 504 incorporates not the constitutional standard applicable to discrimination against the disabled, but the intent standard established by Title VI. But in 1973, some 5 years prior to this Court's decision in Bakke, Congress could only have concluded that Title VI embodied an effect standard. That was the manner in which Title VI had been authoritatively construed

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[23] 119 Cong. Rec. 5862 (1973) (Sen. Cranston.)

since 1964 by the agencies responsible for its implementation,[24] a construction which in 1973 stood unchallenged. This Court may ultimately have interpreted Title VI otherwise in Bakke and Guardians, but "the relevant inquiry is not whether Congress correctly perceived the then state of the law, but rather what its perception of the law was." Brown v. GSA, 425 U.S. 820, 828 (1976).

Finally, petitioners suggest that because of the diversity of handicaps which exist among the disabled, Congress cannot have intended that section 504 prohibit practices with a discriminatory effect. But the application of the effect rule under Title VII is not based on any assumption that all blacks or women are affected in the same manner by employment tests or

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[24] 29 Fed. Reg. 16274-16305 (1964).

standards. There are important differences among minorities and women just as there are among the handicapped. A non-job related written examination which screens out a disproportionate number of blacks, for example, might leave more vacancies for college educated blacks able to pass that test. See Albemarle Paper Co. v. Moody, 422 U.S. 405 (1975). Title VII is nonetheless applicable to such a case, because "Congress never intended to give an employer license to discriminate against some employees on the basis of race or sex merely because he favorably treats other members of the employees' group." Connecticut v. Teal, 457 U.S. 440, 455 (1982). There is no reason to believe that Congress, when it enacted section 504, intended to endorse federally subsidized

practices which discriminated against the blind so long as the practices did not also discriminate against the deaf.

(3) The Agency Regulations and Subsequent Legislative History

The Department of Health, Education and Welfare, the agency originally responsible for coordinating enforcement of section 504, has from the outset interpreted that section to apply to practices with a discriminatory effect.[25] At least 23 other agencies have promulgated similar regulations applying a disparate impact test.[26] The Department of Justice, which is now responsible for coordinating agency

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[25] See 41 Fed. Reg. 20296 (1976) (proposed department regulations), 29560 (1976) (proposed agency regulations); 42 Fed. Reg. 22676 (1977) (final agency regulations); 45 C.F.R. § 84.4(b)(4).

[26] See U.S. Brief, pp.1-2 n.2.

implementation of section 504, requires all federal agencies to promulgate such disparate impact regulations.[27]

The prohibition against practices which have an adverse effect on the disabled is the linchpin of the regulations first issued by HEW in 1976, and now enforced by the Department of Health and Human Services. Section 84.4(b) of the regulations describes four different types of discriminatory effects which are forbidden, including methods of administration which have the effect of substantially impairing for the handicapped the achievement of the

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[27] 28 C.F.R. §§ 41.51(b)(1)(ii), 41.51 (b)(1)(iii), 41.51(b)(3), 41.51(b)(4), 41.54, 41.56.

purposes of a program.[28] Section 84.13 forbids the use of employment tests or selection criteria which have the effect of screening out handicapped persons. Subchapter C of the regulations, 45 C.F.R. §§ 84.21-22, is devoted entirely to assuring that disabled individuals are not excluded from programs because they are physically "inaccessible to or unusable by handicapped persons." Section 84.33(b) requires that the education afforded handicapped students must meet their needs "as adequately as the needs of nonhandicapped persons are met." The criteria for admission to federally assisted college programs may not have a "disproportionate adverse effect on

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[28] 45 C.F.R. § 84.4(b)(4). See also 45 C.F.R. §§ 84.4(b)(1)(ii) (unequal opportunity to participate), 84.4(b)(1)(iii) (services not "as effective as" those provided to the nonhandicapped), 84.4 (b)(5)(locating facility at a site which has the effect of excluding handicapped persons.)

handicapped persons" unless, inter alia, those criteria are in fact validated predictors of success in the education program in question. 45 C.F.R. § 84.-42(b)(2). Academic requirements which "have the effect of discriminating, on the basis of handicap" must be similarly justified. 45 C.F.R. § 84.44(a). The health, welfare and other social services provided to the handicapped must be "as effective as" the services provided to nonhandicapped individuals. 45 C.F.R. § 84.52(a)(3). Wholesale judicial nullification of these effect rules would as a practical matter destroy most of the regulatory scheme established by HEW in 1976.

This Court recognized in Consolidated Rail Corporation v. Darrone that these HEW regulations "particularly merit deference" because "the responsible congressional committees participated in their formu-

lation, and both these committees and Congress itself endorsed the regulations in their final form." 79 L.Ed.2d at 577.[29] HEW first proposed those regulations in May 1976 only after consulting with the relevant committees of both the House and Senate.[30] Senate hearings in that year expressly considered the scope and effectiveness of the oproposals.[31] InJanuary

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29 In Southeastern Community College v. Davis, 442 U.S. 397, 404 n.4 (1979), this Court suggested that HEW chose to rely on the language of section 504 alone until ordered to issue regulations in Cherry v. Mathews, 419 F. Supp. 922 (D.D.C. 1976). In fact, however, the May 1976 proposed regulations were first issued two months before the July, 1976 decision in Cherry.

30 Hearings on Rehabilitation of the Handicapped Programs, 1976, before the Subcommittee on the Handicapped of the Senate Committee on Labor and Public Welfare, 94th Cong., 2d Sess., 1491, 1503-04 (1976)(hereinafter cited as "1976 Senate Hearings".)

31 1976 Senate Hearings 323 (Rep. Dodd), 1502 (Sen. Williams), 1511 (Sen. Williams).

1977, first HEW Secretary Mathews[32] and then HEW Secretary Califano[33] provided each member of Congress with copies of the proposed regulations and solicited their comments. Following the final promulgation of those regulations, a House subcommittee conducted further hearings on the implementation of section 504 at which the Director of HEW's Office of Civil Rights expressly called attention to the various HEW regulations concerning discriminatory effects.[34]

In the spring of 1977, when the proposed section 504 regulations were awaiting final action, members of both the House and Senate repeatedly took the floor

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[32] Hearings on Review of Programs for the Handicapped 1976, before the Subcommittee on the Handicapped of the Senate Committee on Human Resources, 95th Cong., 1st Sess. 73 (1977).

[33] Id. at 76.

[34] Id. at 295-6.

to urge HEW to approve them as written. Representative Koch urged Secretary Califano to sign the regulations "in their current form". 123 Cong. Rec. 10455. Congressman Dodd expressed concern about possible changes in the proposed regulations, insisting "these regulations must not be weakened." Id. at 10823. Senator Cranston called for the "prompt and effective implementation" of the regulations, and wrote to Secretary Califano urging that the draft "be considered presumptively valid" and expressing opposition to any changes that might weaken it. Id. at 12410. Particular support was expressed for the protection the regulations would afford against architectural and related barriers,[35] a protection which

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[35] 123 Cong. Rec. 10455 (Rep. Koch), 10823 (Rep. Dodd), 12216 (Sen. Humphrey), 12410 (Sen. Cranston).

existed solely because the regulations applied to practices with discriminatory effects. The final promulgation of those regulations was greeted with virtually unanimous praise in both houses of Congress, including, significantly, from three of the members primarily responsible for framing section 504 itself, Senators Cranston, Randolph, and Williams.[36]

In 1978 Congress adopted a number of amendments to the Vocational Rehabilitation Act which reflected its approval of the HEW regulations. Section 505(a)(2) was added to make available under section 504 the rights, remedies and procedures of Title VI. The Senate Report explained that this provision was "designed to enhance the

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[36] 123 Cong. Rec. 12760 (1977) (Sen. Randolph), 13342 (Sen. Cranston), 13515 (Sen. Humphrey), 13635 (Rep. Brodhead), 14133 (Rep. Koch), 14552 (Sen. Haskell); 124 Cong. Rec. 30318 (1978)(Sen. Williams.)

ability of handicapped individuals to assure compliance with ... [section 504] and the regulations promulgated thereunder." S. Rep. No. 95-890, 95th Cong., 2d Sess.,18 (1978) (Emphasis added). Congress was well aware that those regulations included an effects standard. Thus, "in adopting section 505(a)(2) in the amendments of 1978, Congress incorporated the substance of the Department's regulations into the statute." Consolidated Rail Corporation v. Darrone,79 L.Ed.2d 568, 577 n.15 (1984).

Congress also enacted several amendments in 1978 which specifically confirmed its knowledge and approval of the effect regulations promulgated the previous year. Section 115(a)(2)provided federal funds for technical personnel "such as interpreters for the deaf ... as may be necessary... in complying with ... the requirements of

section [504] of this Title." 29 U.S.C. § 775(a)(2) (Emphasis added). Section 114(3) authorized grants to train interpreters for the deaf, the Senate Report explaining that this provision was enacted "in response to the requirements imposed by section 504". S. Rep. No.95-890, 95th Cong., 2d Sess. 41 (1978). The debates concerning these provisions reiterated their common assumption that section 504 forbad federally assisted programs from operating in a manner that had a discriminatory effect on the blind or deaf.[37] Section 118(a)(5) of the bill directed the Architectural and Transportation Compliance Board to develop standards and provide technical assistance with regard to the section 504 regulations concerning architectural, transportation and communication barriers. 29 U.S.C. §

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[37] 124 Cong. Rec. 13900 (1978) (Rep. Jeffords), 30580 (Sen. Hatch).

792(d)(3). This proposal necessarily assumed that section 504 applied to physical barriers which had a discriminatory effect on the disabled.[38] Such "subsequent legislation declaring the intent of an earlier statute is entitled to significant weight" NLRB v. Bell Aerospace Co., 416 U.S. 267, 275 (1975).

In decided contrast to these efforts to facilitate enforcement of the HEW regulations regarding practices with discriminatory effects, Congress elsewhere in the 1978 Amendments expressly rejected other HEW regulations construing section

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[38] S. Rep. No. 95-890, 95th Cong., 2d Sess., 17 (creation of "a barrier free environment" one of the "goals of section 504) (referring to "methods short of physical alteration ... to achieve program accessibility under section 504 regulations.")(1978); 124 Rec. 13901 (Rep. Jeffords)(referring to the "physical barrier provisions of 504"), 30326 (Sen. Dole) ("most barriers are erected not because of intentional thought but simply because of a lack of thought").

504. Congress amended section 504 to include executive agencies and the Postal Service, 29 U.S.C. §794, overruling HEW's position that section 504 did not apply to the federal government itself.[39] Congress partially rejected HEW's views regarding the extent of protection afforded by section 504 to drug addicts and alcoholism.[40] Under these circumstances the failure of Congress to revise or repeal HEW's regulations interpreting section 504 to cover practices with discriminatory effects, indeed the absence of the slightest criticism of that construction, "is persuasive evidence that the interpretation is the one intended by Congress." NLRB v. Bell Aerospace Co., 416 U.S. 267, 275

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[39] 124 Cong. Rec. 13901 (1978).

[40] Compare 29 U.S.C. § 706(7)(b) with 45 C.F.R., Pt. 84, App. A ¶4. See also 124 Cong. Rec. 30322 (1978) (Sen. Cannon).

(1975). "Where 'an agency's statutory construction has been "fully brought to the attention of the public and Congress," and the latter has not sought to alter that interpretation although it has amended the statute in other respects, then presumably the legislative intent has been correctly discerned.'" North Haven Board of Education v. Bell, 456 U.S. 512, 535 (1982).

II. THE AGENCY REGULATIONS PROHIBITING PRACTICES WITH A DISCRIMINATORY EFFECT ARE REASONABLY RELATED TO SECTION 504, EVEN IF THE STATUTE ITSELF APPLIES ONLY TO CASES OF DISCRIMINATORY PURPOSE

The authority of a federal agency charged with the responsibility of administering a statute extends to the promulgation of regulations which are reasonably related to the purpose of the statute, even if the statute by itself does not contain the same requirements found in the

regulations. In Guardians Association v. Civil Service Commission, 77 L.Ed.2d 868 (1983), a majority of this Court held that the Title VI regulations establishing an effect standard were valid, despite the fact that Title VI by itself applied only to cases of discriminatory purpose. 77 L.Ed.2d at 875 and n.13 (White, J.), 894 n.15 (Marshall, J., dissenting), 708-9 (Stevens, J., dissenting). Thus even if this Court were to conclude that section 504, like Title VI, prohibits only actions with a discriminatory purpose, the majority view in Guardians makes clear that the applicable HHS effect regulations would still be valid.

This Court has repeatedly held that the authority of an administering agency extends in appropriate cases to prohibiting or requiring conduct which is not forbidden or required by the statute pursuant to

which the regulations were issued. In Mourning v. Family Publications Service, 411 U.S. 356 (1973), the respondent challenged a regulation issued by the Federal Reserve Board which required the disclosure of certain credit terms in any consumer transaction involving more than four instalments, regardless of whether or not a finance charge was imposed. The Truth in Lending Act under which the regulation was issued required such disclosures only if a finance charge was in fact being collected. This Court upheld the regulation as reasonably justified as a method of assuring compliance with the statute in cases in which a finance charge might have been built into the purchase price of the goods. 411 U.S. at 369-371. In Gemsco, Inc. v. Walling, 324 U.S. 244 (1938), the regulation in controversy forbade employers from allowing or requiring industrial

homework. The underlying statute, the Fair Labor Standards Act, did not even refer to industrial homework. The regulation was nonetheless upheld as reasonably framed to prevent evasion of the statutory minimum wage by means of piecework rates that yielded wages below that minimum. 324 U.S. at 255.

The rationale of Mourning and Gemsco is clearly applicable to statutes concerning discrimination. In both of those cases the responsible agency reasonably concluded that it was not administratively feasible to investigate and decide in each invididual instance whether there was a covert violation of the law, and that effective enforcement of the statute thus required the promulgation of a somewhat broader but considerably more administrable rule. In the case of discrimination against the handicapped it is often not

only impracticable but meaningless to attempt to distinguish between discriminatory purpose and discriminatory effect. A federally assisted recreation program which had a policy of excluding deaf children would clearly be covered by section 504. But a requirement that all applicants pass some test which required an ability to hear, although indistinguishable in operation from an express prohibition against the deaf, would not on its face constitute intentional discrimination. Deliberate discrimination when it occurs against the disabled is ordinarily based, not on any malice toward handicapped individuals, but on a good faith but inaccurate understanding of what abilities are in fact necessary to participate in a program. That misunderstanding may manifest itself in a rule expressly directed at the disabled, or simply in a rule establishing

unnecessary or arbitrary prerequisites to participation. A regulation which attempted to distinguish between these two types of practices, forbidding the former while permitting the latter, would change only the form but not substance of the practices which section 504, even on petitioners' view, was adopted to eliminate.

III. TENNESSEE'S 14 DAY RULE HAD A DISCRIMINATORY EFFECT ON THE HANDICAPPED

The practical issue presented by this case is not whether section 504 requires Tennessee to maintain any particular level of Medicaid expenditures.[41] Every one of the

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[41] Whether the Medicaid Act itself may require a state to maintain a particular level of services is not at issue in this case. This Court expressly reserved decision on that issue in Beal v. Doe, 432 U.S. 438, 444 (1977). The United States argued that the Act contained such a requirement in its brief in Williams v. Zbaraz, 448 U.S. 358 (1980).

fifty-three jurisdictions which participates in the Medicaid program faces financial problems similar to those in Tennessee, but the overwhelming majority have utilized cost control methods different from that complained of in this case. According to a federal study of Medicaid programs, which was introduced at trial, fifteen states control such costs without placing any direct limitation on inpatient hospital services.[42] Thirteen other states, together with the District of Columbia and Virgin Islands, require prior authorization for some or all hospitalization, a process which permits consideration of the actual medical needs of each patient.[43] A growing number of states achieve the same result by

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[42] J.A. 159-66.

[43] Id.

establishing a pre-determined amount that will be paid for each treatment based on the patient's diagnosis.[44] Five states limit the number of days of hospitalization per admission, a practice which expert testimony in this case indicated is both simple to administer and devoid of any adverse impact on the handicapped.[45] Four other states restrict the number of days per spell of illness.[46] Only 9 states restrict the number of days of hospitalization per year; of these Tennessee's rule was in 1980

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[44] There were four such states as of August, 1984, Utah, Pennsylvania, Ohio and New Jersey.

[45] J.A. 60-61, 101-02, 106-07, 115-16, 120-21, 126, 129, 159-66. This per stay limitation is easier to administer than Tennessee's 14 day rule, since it does not require the state or a hospital to review a patient's medical history over the current fiscal year merely to determine his or her eligibility for hospitalization coverage.

[46] J.A. 159-66.

the most drastic in the nation.[47] As of that year the states other than Tennessee which funded only a fixed number of hospital days a year set an average ceiling of 37.6 days; Tennessee's 14 day rule was less than half that average.

The defendants are free to reduce Tennessee's Medicaid costs by means of any of the methods utilized in other states,[48] which bear equally on the handicapped and nonhandicapped alike, while satisfying the Medicaid Act's requirement that reimbursement policies "assure that individuals

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[47] A private study of state Medicaid programs referred to by the United States contains essentially similar information, although it indicates the Tennessee rule is now only the second most severe in the nation. (U.S. Br. 10a).

[48] A number of other methods, in addition to those described in the text, are used outside Tennessee to control hospital costs. J.A. 161 (Puerto Rico), 163 (Michigan, Nevada), 164 (Guam), 166 (Washington).

eligible for medical assistance have reasonable access ... to inpatient hospital services of adequate quality." 42 U.S.C. § 1396a(a)(13). Indeed, the Tennessee legislature[49] has recommended that the state adopt a diagnosis related reimbursement plan, an approach already applied in several state Medicaid systems and utilized by the federal government under Medicare.[50] Respondents ask not that Tennessee apply to

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49 The Medicaid System of the Tennessee Department of Public Health, A Report of the Special Joint Committee to the Ninety-Third General Assembly, 24, 26 (1983). The Committee criticized the method by which state officials had reduced inpatient expenditures, noting that the cutback "has forced an unfair burden for cost containment efforts upon a small number of [public and non-profit] hospitals [which treat a high volume of Medicaid patients] and the counties which support these hospitals." Adoption of a diagnosis related reimbursement system was recommended as a means of reducing the burden on the hospitals "while assuring that Medicaid clients and the public are guaranteed a source for acute care." See n.44, supra.

50 42 U.S.C. § 1395ww.

the handicapped a different rule than that applicable to the nonhandicapped, such as a 20 day ceiling rather than 14 days,[51] but that the state adopt a single rule for all which is neutral not only on its face but also in its impact.

This case thus presents no issues regarding the financial costs which may in other instances be involved in complying with the mandate of section 504. Petitioners did not assert in the court below, and do not claim in this Court, that the non-discriminatory methods utilized in other states to reduce Medicaid costs would be in any way less efficacious in Tennessee. (See Pet. App. A20 n.12) This is not a case like Davis v. Southeastern Community College, 442 U.S. 397 (1979), in

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51 Indeed, the Medicaid statute itself precludes such special treatment. 42 U.S.C. (Supp. V) § 1396a(a)(10) (B).

which the federal grantee adduced persuasive evidence that altering its program to accommodate the needs of certain disabled individuals would not be feasible. Here the Tennessee officials who testified at trial never suggested that the Medicaid limitations under challenge were in any way preferable to the less burdensome alternatives.[52] There was no claim that the selection of the 14-day rule was based on any analysis of the medical needs of Medicaid patients, of the most efficacious method of administering the program, or of any other consideration. Indeed, Tennessee officials apparently preferred to lower Medicaid costs by reducing the reimbursement paid to inefficient hospitals,[53] a

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[52] J.A. 40, 68-69, 96; Transcript of August 15, 1980, pp. 99-105.

[53] Excess bed capacity, which petitioners had proposed to penalize, was one of the major reasons for the high cost of hospitalization in Tennessee. In 1980 only 70.9% of the State's licensed hospital beds

solution which would clearly have had no adverse impact on the handicapped, but that plan was abandoned at the last minute in part because of opposition by the hospital industry. (Pet. App. A14; J.A. 46-47).

In short, petitioners have consistently undertaken to defend this action, not on the ground that there was an important reason for selecting the 14 day rule as the method of limiting the state Medicaid program, but by insisting that Tennessee is free to adopt that or any other rule for no reason at all. Petitioners have offered no justification for their choice of this particular alternative, and simply insist

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were occupied. Final Report of the Special Committee on Hospital Cost Containment, 91st Tennessee General Assembly (1980). The Tennessee State Health Plan, 1970-84 noted that such excess capacity had been found to "contribute to the high cost of hospital care with little or no health benefits.

that they are under no legal obligation to do so. (See Pet. Br. 24). Petitioners expressly concede that they can offer no explanation of why even the original 20 day rule was established. (Id., 7 n.10).[54] They contend, not that the reasons for selecting the 14 day limitation should be given

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[54] Whether the 20 day rule itself had a disparate effect on the handicapped is not clear from the present record. To acertain the effect of that rule it would be necessary to know how many handicapped and nonhandicapped patients require 21 days or more of hospatilization in a year. The record contains no such information.

If the 20 day rule did have such a disparate impact, that effect would under the sixth circuit decision constitute a prima facie case of a violation of section 504. Its ultimate legality would depend in part on the nature and importance of whatever justification might exist for the 20 day rule. The state conceded at trial it would not even explain why the 20 day rule was adopted. (J.A. 45, 67).

controlling legal importance, but that the lack of any such articulated reasons is legally irrelevant.[55]

The sixth circuit, noting the extremely narrow grounds on which the 14-day rule has until now been defended, directed that the district court afford the state another opportunity to adduce a justification for that practice. Under the decision of the court of appeals, proof of the existence of a practice with an adverse effect on the

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55 Even prior to the present controversy, Tennessee has opposed to scrutiny of whether its Medicaid program was being operated in violation of section 504. The state pledged, in order to receive federal Medicaid funds, that it would periodically review its program to ensure that it did not discriminate against the handicapped, but in fact never undertook any such internal audits or evaluations. (J.A. 42, 96-97, 135, 136). All administrative complaints alleging discrimination against the handicapped have been disposed of in such a way as to make them inaccessible to federal auditors, in violation of re presentations made by the state in order to obtain federal Medicaid funds. (J.A. 42, 144 ¶ 9).

disabled is to be treated as establishing only a prima facie case of unlawful discrimination under section 504. See Connecticut v. Teal, 457 U.S. 440,447 (1982). The appellate court articulated certain standards to be applied on remand in determining whether that prima facie case had in this case been rebutted. (Pet. App. A12-A16). Neither party sought certiorari regarding this aspect of the sixth circuit opinion, and the correctness of the particular standards established by that opinion is not before this Court. Thus an affirmance by this Court of the sixth circuit's finding of an unlawful discriminatory effect would not be conclusive of this litigation, but will merely shift to petitioners the burden of establishing on remand a legally sufficient

justification for selecting the 14-day rule as the method of limiting the state's Medicaid program.

Since this case was decided by the district court in June, 1981, there have been significant changes in the Tennessee Medicaid program. First, Tennessee has restored 20 days per year of inpatient hospital coverage to individuals under the age of 21 who are receiving early periodic screening, diagnosis, and treatment services.[56] Second, Tennessee has redefined the eligibility requirements for Medicaid so as to exclude entirely from that program a substantial number of individuals who were covered by Medicaid in 1980.[57] As a

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[56] See U.S. Br. 8a. Federal law expressly allows greater inpatient care to be given to such children. 42 U.S.C. §§ 1396a(a)(10)(I), 1396d(a); 42 C.F.R. § 441.57.

[57] This change was accomplished by excluding from the Medicaid program most individuals classified as "medically needy." See Schweicker v. Gray Panthers, 453 U.S. 34, 37-38 (1981). Copies of the

result of these changes in the 14-day rule as it existed at the time of trial, some of the handicapped patients adversely affected by the 14-day rule are now entitled to 20 days of hospitalization per year, and some of the nonhandicapped patients who were not affected by the 14-day rule now no longer receive any hospitalization at all under Medicaid.

Whether under the eligibility rules now in operation the adverse impact of the 1980 rule has been aggravated, mitigated, eliminated, or altered in some other legally relevant manner the record does not disclose and we do not know. Since this is an action for injunctive relief, respondents' right to any remedy depends on the substance and effects of the 1984

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453 U.S. 34, 37-38 (1981). Copies of the state rules altering the eligibility of such medically needy patients have been lodged with the Clerk.

rules, not of the rather different rules which were in effect in 1980. Under these circumstances the appropriate disposition of this case would appear to be to remand it for an evidentiary hearing to ascertain what effect the 1984 rules now have on handicapped Medicaid patients. See Spomer v. Littleton, 414 U.S. 514 (1974). On the assumption, however, that the Court may wish to resolve the issues that were presented by the 1980 rules, we set forth our views on those questions.

(1) The Nature of Tennessee's 1980 Medicaid Restrictions

The 14 day rule in effect in 1980 had a peculiarly selective effect. Of approximately 51,000 annual Medicaid patients, 44,000, those who needed less than 15 days of hospitalization in a year, were entirely exempt from any reduction in Medicaid

services. All of the cost savings were made by reducing the services provided to the comparatively small group of patients, less than 15% of the total, who required 15 days or more of medical treatment in the same fiscal year. The 7,000 indigent Medicaid recipients picked to bear all of the burden of the reduction in services were chosen, not because their medical needs were less serious, or because they were somehow abusing the Medicaid system, but merely because they had the ill fortune to be too sick, or to be sick too often, in a particular fiscal year. Over 63% of those adversely affected by the 14 day rule were handicapped, while 72% of the group unaffected by the rule were nonhandicapped.

The harsh impact of the 14 day rule was felt when a Medicaid patient, having used up his or her allotted two weeks of coverage, again required hospitalization

for treatment of an injury or illness in the same fiscal year.[58] The undisputed evidence at trial demonstrated that it was frequently impossible in Tennessee for a sick or injured indigent individual to obtain admission to a hospital once his or her annual Medicaid coverage was exhausted.[59] Even some critically ill patients could not obtain hospital care.[60] One doctor, for example, described his experience trying to save the life of the victim of a car accident who, although literally bleeding to death, had been turned away at a series of Tennessee hospitals. (J.A.

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[58] If a patient exhausts his or her 14 days while still undergoing treatment, Tennessee hospitals will nonetheless not discharge the patient without the physician's approval. J.A. 53-54, 106, 116, 129.

[59] J.A. 50-52, 100-02, 116, 121-23.

[60] J.A. 125-26, 129; transcript of hearing of February 17, 1981, pp. 5-7.

124). At best indigent patients faced a substantial likelihood that, once their allotted days were exhausted, they would be denied hospitalization until their condition had deteriorated sufficiently to become life threatening. (J.A. 48-58).

This system had a number of anomalous aspects. For the first few weeks in July, the beginning of the fiscal year, all Medicaid eligibles were able to obtain admission to Tennessee hospitals. As the fiscal year progressed, and allotments were used up, an increasing number of those Medicaid patients were denied both Medicaid coverage and admission to hospitals in the state. By June some 7,000 Medicaid patients faced rejection if they needed and sought hospitalization. For these patients the 14 day rule compelled postponement of treatment for medical problems which arise late in the fiscal year; a patient whose

illness needs 2 days of hospitalization in May must generally wait until July, even though by then his or her condition may have deteriorated so much as to require a week or more of treatment.

The ceiling has nothing to do with a patient's total Medicaid costs. A patient who has already received $10,000 in outpatient treatment, tests and medication still is entitled to 14 days of hospitalization, while a patient whose previous 14 days of hospitalization and other treatment cost only $5,000 cannot hospitalization. If two Medicaid patients sustain identical injuries in an automobile accident, one may receive needed hospitalization, while the other is denied it solely because of treatment earlier in the year for some entirely unrelated condition. A patient hospitalized from June 2 to July 2 continues to receive hospitalization coverage;

an otherwise identical patient hospitalized from June 15 to July 15 would thereafter be denied hospitalization for eleven and a half months.

(2) The 1980 Rules Had A Discriminatory Effect Within the Scope of Section 504

Neither the peculiarities of the manner in which this rule operated, nor the fact that it deprived only about 7,000 of the 51,000 Medicaid patients of benefits, were by themselves of importance under section 504. So long as the burdens of these or any other restrictions do not fall more heavily on the handicapped, section 504 has no application. But in this case the method of selecting the 7,000 patients whose benefits were to be reduced did not fall equally on the disabled and non-dis-

abled alike. As of 1979-80 the number of patients affected by the rule was as follows:

	Handicapped	Non handicapped
Total patients	16,852	34,288
Patients Hospitalized 14 days or less	12,235	31,626
Patients Hospitalized 15 days or more[61]	4,617	2,662

[61] Pet. App. 31-32; J.A. 170-72, 182-84.

These statistics, prepared by the defendants, treat as "handicapped" individuals who are blind or disabled within the meaning of the Social Security Act. (42 U.S.C. § 1382(a)(A)). The group of handicapped individuals covered by section 504 is somewhat broader. See 29 U.S.C. § 706(7)(B). The method used by Tennessee to calculate the effect of the 14 day rule is similar to the methodology that is utilized by the Office of Civil Rights of the Department of Health and Human Service to ascertain the impact of the 14 day rule. (J.A. 148, 155-56). Both courts below accepted these statistics as accurately reflected the effect of the 14 day rule on Medicaid patients who were handicapped within the meaning of section 504. The court of appeals noted the state's methodology tended to understate the adverse effect of the 14 day rule. (Pet. App. A11.)

Handicapped patients were 33.0% of those receiving hospital care, but 63.4% of the patients selected to bear the burden of the Medicaid cuts.[62] Under the 14-day rule, 92.2% of the non-handicapped patients were provided all the hospital care they needed,

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Both parties to this litigation stipulated that the defendant's statistics accurately depicted the impact of that rule on individuals protected by section 504. (J.A. 40; see also J.A. 94, 156).

The Solicitor General, apparently disagreeing with the methodology of the Department of Health and Human Services, urges that this case be remanded with instructions to reopen this issue. (U.S. Br. 7 n.13). But the Solicitor General, like this Court, is obligated to accept the concurrent factual findings of the two courts below and the binding stipulation entered into by actual parties.

[62] The court of appeals noted that while these statistics were analyzed in several different ways by both parties, all the analyses demonstrated that the 14 day rule would have a disproportionate adverse impact on the handicapped. (Pet. App. A11).

but only 71.6%[63] of all handicapped patients received similarly complete coverage. Thus 27.4% of handicapped patients faced the prospect of being denied admission to a Tennessee hospital because they had exhausted their allotted Medicaid days, compared to only 7.8% of non-handicapped patients. Medical experts explained at trial that many of the illnesses which

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[63] The state asserts that 95% of all "eligible handicapped individuals" would have all of their "inpatient hospitalization needs" met despite the 14 day rule., (P. Br. 10, 21). This calculation severely understates the effect of the 14 day rule by including in the group not harmed by that rule 73,816 handicapped individuals who are eligible for hospitalization but who are not never sick enough to require any hospitalization. (See Pet. App. A31-A32). Obviously the effect of a reduction in hospitalization must be assessed by considering only its impact on hospital users; Medicaid eligibles who do not actually use Medicaid hospitalization have no "inpatient hospital needs" to meet. See Hazelwood School District v. United States, 433 U.S. 299, 308 (1979).

leave victim partially or totally disabled often require repeated, sometimes lengthy, hospitalization during the year. Among those chronic and disabling diseases are strokes, leukemia, sickle-sell anemia, degenerative neurological diseases such as multiple sclerosis, and obstructive lung diseases such as asthma and bronchitis. (J.A. 100, 108-10, 111-13, 118-20.). The state candidly acknowledged in its appellate brief that "the handicapped population of Medicaid recipients would suffer proportionately more from the reduction in hospital benefits than the nonhandicapped Medicaid recipients." (Pet. App. A11 n.7.) The issue presented by this appeal is whether the state's practices, which concededly "fall more harshly on one group than another", Connecticut v. Teal, 457 U.S. 440, 447 (1983), have the type of discriminatory effect which is covered by

section 504 and the applicable regulations.

The 14 day rule is inconsistent with several aspects of section 504 and the applicable regulations. First, under the 14 day rule approximately 7,000 otherwise eligible Medicaid patients, two-thirds of them disabled, are literally denied needed Medical hospitalization services.[64] The 4,000 disabled patients involved are denied access to those services for differing periods of time, depending on whether they use up their annual allotment early or late in the fiscal year. At least at some point during the fiscal year, however, each of

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64 This case is clearly distinguishable from Doe v. Coulotti, 592 F.2d 704 (3rd Cir. 1979). In Doe the state did not cover private psychiatric inpatient case under its Medicaid program to the same extent that it covered inpatient hospital treatment for physical illness. Since such psychiatric case was not subject to any reimbursement from the federal government, the third circuit properly held section 504 inapplicable.

these 4,000 handicapped Medicaid patients becomes sick enough to require hospitalization but cannot obtain it.

If Tennessee adopted a rule which barred for 12 months of the year the same predominantly handicapped group of patients, the violation of section 504 would be obvious. These individuals are undeniably "otherwise qualified" in the sense that they have the same medical needs, require the same treatment, and are indigent to the same degree as those who are provided with Medicaid hospitalization. If they were denied such services on a year round basis, they would clearly be "excluded from the participation in ... [a] program or activity receiving federal financial assistance."

Section 504 is no less applicable merely because under the 14 day rule the affected handicapped patients are only

denied hospital services during part of the year. Nothing in the language of the statute limits its application to exclusions which endure throughout an entire calendar or fiscal year. An exclusion for any period of time falls within the literal scope of section 504. If Tennessee in June of each year removed for one month the ramps providing wheelchair access to federally assisted programs in the state, no one would seriously suggest that the previous 11 months of access somehow were sufficient to comply with the law. Congress never intended to give a federal grantee a license to discriminate against the handicapped at one point in time merely because he had earlier treated them favorably. See Connecticut v. Teal, 457 U.S. 440, 455 (1982).

Tennessee insists that the patients denied hospitalization are not technically excluded from the program. But meaningful participation in Medicaid consists of being treated when sick or injured, not in the empty privilege of possessing an unusuable Medicaid card and reminiscing about past visits to the hospital. The period of exclusion under the 14 day rule lasted less than a year, but if its effect does not constitute exclusion from a federally assisted program, the state would be free to establish a far longer period of exclusion. Patients who used 14 days of hospitalization within a given period could be excluded from the program for 5 or 10 years, or for life. Nothing in the language of section 504 or the applicable regulations countenances treating such exclusions as if they were a form of participation. Whether or not a Medicaid

patient is "excluded" from Tennessee's program on a particular day turns on whether or not he or she actually receives needed hospitalization, not on the reasons which may have prompted the state to deny that treatment.

The Solicitor General relies on a commentary to the HHS regulations which explains that a burn treatment center "need not provide other types of medical treatment to handicapped persons unless it provides such medical services to non-handicapped persons." 45 C.F.R. Pt. 84, App. A, ¶ 33. The evident purpose of that commentary is merely to make clear that the states are authorized to establish specialized hospitals, and that a recipient's obligation to take resonable steps to accommodate the disabled does not require it to treat deafness at an eye hospital. The instant case, however, involves no

specialized facilities. The problem is not that Tennessee hospitals are ill equipped or unable to treat the medical problems of the handicapped, but that the state is unwilling to pay for that care. In Tennessee not even a burn treatment center will admit a disabled burn victim if he or she has already exhausted his or her allotted 14 day of care.

Even if the handicapped individuals adversely affected by the 14 day rule are not regarded as being excluded from Medicaid during a portion of the year, it is nonetheless indisputable that they receive a very different type of medical care than most patients. The overwhelming majority of all nonhandicapped patients remain eligible for hospitalization whenever they need it throughout the year; thousands of other handicapped patients, on the other hand, must wait to actually

receive needed services until the next fiscal year. In some instances such delays in receiving medical care can be literally fatal. Delay will often result on a serious deterioration in a patient's condition, ultimately leading to more radical or dangerous forms of treatment. Paraplegics, for example, are particularly susceptible to decubitus ulcers, more commonly known as bedsores; treated promptly this is ordinarily a relatively minor illness, but left untreated it can lead to amputation of the limb involved. Even where such severe consequences are not involved, a postponement of hospitalization will often mean that the patient must endure weeks or months of pain or disability until the coming of the new fiscal year brings with it the overdue hospitalization.

The dangers and suffering which are occasioned by the delays compelled by the 14 day rule fall far more heavily on handicapped patients. More than 1 in 4 handicapped Medicaid patients are subject to such delays in Tennessee, compared to less than 1 in 13 nonhandicapped patients. This type of disparate impact falls within the scope of several of the applicable regulations of the Department of Health and Human Services. First, section 84.4(b)(4) provides:

> A recipient may not ... utilize criterion or methods of administration ... that have the ... effect of defeating or substantially impairing accomplishment of the objectives of recipient's program with respect to handicapped persons....

Second, section 84.4(b)(1)(iii) forbids a recipient from providing "a qualified person with an aid, benefit or service that

is not as effective as that provided to others...." See also 45 C.F.R. § 84. 52(a)(3).

The application of these regulations to the facts of this case is clear. A method of administration which delays the medically necessary hospitalization of 4,000 handicapped patients each year undeniably "substantially impair[s]" for them the accomplishment of the manifest goals of the Medicaid program. Tennessee law expressly states that the objective of the state Medicaid program is "to prevent, diagnose, correct and cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with [a patient's] capacity for normal activity, or threaten some significant handicap ...." T.C.A. § 14-23-103(2).[65] The

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[65] The Solicitor General appears to argue with regard to this regulation that the phrase "objectives of the recipient's program" in section 84.4(b)(4) refers not

objectives of a recipient's program must in any event include furthering the purposes of the federal program under which it is funded, and healing the sick is certainly the goal which led Congress to enact the Medicaid Act in 1964. See 42 U.S.C. § 1396. The achievement of these federal and state objectives is interferred with severely,

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to the goal of that program, but merely to the act of providing the service intended to achieve that goal. On that reading the "objective" of Tennessee's program would be, not to cure the sick, but merely to provide 14 days of hospitalization, regardless of whether that period of hospitalization was sufficient, or perhaps, even necessary. That is, the "objective" of providing 14 days of hospitalization, the government appears to suggest, is to provide 14 days of hospitalization. This is, at the least, an extremely peculiar construction of the term "objective", a term which usually refers to the ultimate goal of an activity, not to the manner in which that activity occurs.

and in some instances possibly fatally, by postponing needed hospitalizaton for thousands of handicapped patients.

It is equally apparent that the selective imposition of those delays on a predominantly handicapped group of patients provides them with a type of medical care which is decidedly less effective than that afforded to almost all non-handicapped patients. 45 C.F.R. § 84.4(b)(1)(iii). Delayed treatment will often be less efficacious treatment, and even the most skilled care cannot undo the suffering that will have occurred because needed care was postponed, not for any medical reason, but merely to await the arrival of the next fiscal year. Where medical needs are concerned, treatment delayed is invariably treatment denied.

(3) The "Same Service" Defense

Petitioners and the Solicitor General, while acknowledging the undeniable adverse impact of the 14 day rule, insist that that impact is as a matter of law irrelevant. Both argue that section 504 of the HHS regulations are fully satisfied whenever the handicapped receive from a federally assisted program the "same service" that is provided to nonhandicapped individuals. Petitioners assert that thelaw "require[s] only that aids, benefits and services, be provided in like kind to both the handicapped and nonhandicapped." (Pet. Br. 23) The United States suggests "A person who offers the same goods and services ... to all ... is treating all ... equally ... is not discriminating against any of them." (U.S. Br. 22). Tennessee's practices cannot be accurately characterized as providing equal access to hospitalization.

By June of each fiscal year Tennessee is not offering the same services to every qualified patient; some 4,000 handicapped patients are not offered hospitalization at all.

Petitioners' view of section 504 and the HHS regulations has been repeatedly rejected both by the United States and by this Court. Section 84.4(b)(1)(iv) notes that under certain circumstances:

> provid[ing] different ... aids, benefits, or services ... is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others.

See also 45 C.F.R. § 84.5(a)(5). The official HHS commentary to the regulations notes that "in order to meet the individual needs of handicapped persons to the same extent that the corresponding needs of

nonhandicapped are met, adjustments to regular programs or the provisions of different programs may be necessary." 45 C.F.R. Pt. 84 App. A ¶ 6. The explanation of the HEW regulations issued in May 1977, when the final regulations were promulgated, emphasized

> [I]n the past many handicapped persons have been excluded from programs entirely or denied equal treatment, simply because they are handicapped. But eliminating such gross exclusions and denials of equal treatment is not sufficient to assure genuine equal opportunity. In drafting a regulation to prohibit exclusion and discrimination, it became clear that different or special treatment of handicapped persons, because of their handicaps, may be necessary in a number of contexts in order to ensure equal opportunity.... 42 Fed. Reg. 22676 (1977).

HEW Secretary Mathews, in a commentary published with the first draft of these regulations, noted "Handicapped persons may require different treatment in order to be afforded equal access to federally assisted

programs and activities, and identical treatment may, in fact, constitute discrimination." 41 Fed. Reg. 20296 (1976).

This Court rejected the same argument now advanced by Tennessee in Lau v. Nichols, 414 U.S. 563, 568. (1977) In Lau the federally assisted public school classes and materials were ordinarily in English. The city conducted special English language instruction classes for many but not all of the students who entered the school system speaking only Chinese. 414 U.S. at 564 and n. 1. The Chinese speaking students unable to obtain admission to those classes asserted that these practices violated the Title VI regulations. The court of appeals had held that these students were entitled only to "the same facilities, text books, teachers and curriculum as is provided to other children...." 483 F.2d 791, 799 (9th Cir. 1973). The city pressed here an

argument indistinguishable from that now advanced by Tennessee, insisting that it had "not erected physical barriers at the school house doors."[66] This Court reversed the decision of the court of appeals, relying in particular on section 80.3(b)(2) of the HEW Title VI regulations, a provision which, in language virtually identical to section 84.4(b)(4) of the section 504 regulations, forbad federal grantees from utilizing methods of administration which had "the effect of defeating or substantially impairing accomplishment of the objectives of the program as respects individuals of a particular ... national origin."[67] The Court emphasized "there is

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66 Brief of Respondents, 5, 20.

67 See also Memorandum for the United States, pp. 10-11.

is no equality of treatment merely by providing ... the same facilities, textbooks, teachers, and curriculum ... for students who do not understand English". 414 U.S. at 566, 568.[68]

Petitioners point to no provision of the section 504 regulations which purports to immunize from scrutiny practices which have the effect of excluding handicapped individuals from a program merely because

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68 The United States argues that a federal recipient would be insulated from Section 504 scrutiny if it provided all program participants with a voucher of equal dollar amount to purchase goods and services. (U.S. Amicus Brief at 13, 22-23, 25). That hypothetical example is of little relevance here, since Title XIX so clearly precludes such a policy. This Court has expressly held that the obligation to treat individuals equally is at times violated by providing identical amounts of money which in fact purchase unequal services. Arizona Governing Board of Norris, 77 L.Ed.2d 1236 (1983). The school board in Lau could not have satisfied the mandate of this Court by providing students with a voucher sufficient in amount only to pay for English language instruction.

that exclusion is based on the receipt of past services. Neither do they suggest that the language of the methods of administration regulation applied in Lau requires automatic approval of any program providing the same service to all. Petitioners argument, like that of the Solicitor General, is limited to a contention that such a per se defense is somehow to be found in the equal effectiveness regulations, 45 C.F.R. §§ 84.4(b)(1)(iii), 84.52(a)(3).

The literal language of sections 84.4(b)(1)(iii) and 84.52(a)(3), however, expressly contemplates an inquiry into the actual effectiveness of the services provided to the handicapped. But Tennessee and the Solicitor General suggest that the plain meaning of these regulations is limited by 45 C.F.R. § 84.4(b)(2), which provides:

> For the purposes of this part, aids, benefits, and services, to be equally effective, are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons, but must afford handicapped persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement, in the most integrated setting appropriate to the person's needs.

Petitioners contend that this provision "dramatically qualifie[s]" sections 84. .4(b)(1)(iii) and 84.52(a)(3), and requires only that services "be provided in like kind to both handicapped and nonhandicapped." (Pet. Br. 23) This construction of section 84.4(b)(2) simply flies in the face of the language of that section, which squarely holds that services of a "like kind" are insufficient if they afford unlike opportunites for achievement or satisfaction to handicapped and nonhandicapped participants.

The Solicitor General offers a more sophisticated misreading of section 84.4(b)(2), insisting that that section requires only that "the handicapped must be given an 'equal opportunity'" to get the same service "(whatever that may be) that the State offers to others." (U.S. Br. 14). This unlikely construction of section 84.4(b)(2) ignores that provision's insistence that handicapped participants be afforded an equal opportunity to "obtain the same result" and reach "the same level of achievement" as others. If a Medicaid program is structured in such a way that in June of each year nonhandicapped patients can obtain hospital treatment, but handicapped patients cannot, the handicapped patients clearly do not have the same opportunity as the others to obtain the cure which results from such treatment.

The government's faulty analysis derives in large measure from a misreading of the term "benefit" in section 84.4-(b)(2), an error which pervades the the Solicitor's brief. The noun "benefit" has two distinct meanings, it can refer either to a valuable good or service ("fringe benefit"), or to the advantage or gain derived from that good or service ("for the benefit of mankind"). Which meaning of "benefit" is intended is ordinarily apparent from the context in which the word is used. That term is used in both senses in section 84.4(b)(2), which explains that "benefits ... to be equally effective ... must afford handicapped persons equal opportunity to obtain the same ... benefit." Here the first "benefit" refers to the particular type of assistance provided, and the second "benefit" to the advantages derived from that assistance. That is

apparent from the overall structure of the sentence; the regulation simply makes no sense if it provides, as the Solicitor suggests, that a particular service is "equally effective" if it provides an equal opportunity to obtain itself. The doctrine of in pari materia supports a similar conclusion; "benefit" first appears in a list which includes aids and services, but its second use is in a list including result and level of achievement.

The error in the Solicitor's interpretation of the phrase "same benefit" is signaled by the fact that while section 84.4(b)(2) asserts that the handicapped must "gain" the same benefit, the government's brief paraphrases the regulation as requiring that the participant "get" the same benefit. (U.S. Br. 15) The verb "gain" is used with "benefit" only where "benefit" refers to the advantage or value

which accrues to someone; a participant "gets" a service and "gains" an advantage from that service.

In this case , of course, respondents actually seek only the same service at the end of a fiscal year that is available to nonhandicapped patients. But in other contexts the "same service" defense would lead to a number of anomalous results. Were this defense recognized, a recipient might be obligated to take steps to remove physical barriers which prevent a handicapped individual from entering the room in which a federally assisted activity occurred, but would be under absolutely no obligation to make those services useful to that individual once he or she entered. Thus a federally assisted summer camp attended by paraplegic children would be obligated by section 504 to provide a ramp at the entrance to its recreation building,

but could limit the activities in that building to hopscotch, skipping rope, tap dancing and roller skating. A practice which resulted in a 10% difference in the proportion of handicapped and nonhandicapped individuals admitted to a federally assisted program would be suspect, but a practice which caused a 100% difference in the effectiveness of that program would be immune from scrutiny. Section 504 would be violated if some practice prevented the participation of the disabled in a minor part of a program, but not if the entire program failed to meet or address their needs.

The Solicitor General also attacks the decision of the court of appeals[69] as

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[69] Central to the Solicitor General's attack on the Court of Appeals' holding is its characterization of that holding as a requirement "that the handicapped be assured of the same success rate as the non-handicappedinachieving[goodhealth]". In fact, the appellate court was doing nothing more than enforcing the quite

involving "affirmative action", a requirement which the government urges was disapproved by Southeastern Community College v. Davis, 442 U.S. 397 (1979). (U.S. Br. 21, 23, 26) Under Southeastern Community College, he suggests, a federal grantee is never obligated to spend any additional funds, or take any other form of positive action, merely because of the particular needs of disabled individuals

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different requirement of the Department of Health and Human Services that the handicapped "be given an equal opportunity to succeed at the goal of the [Medicaid] program." (Pet. App. A12, n.8, citing 45 C.F.R. 84.4(b)(2).) It would obviously be impossible, simply as a function of the limits of medical science and the reality of human frailty, to order that any group of patients be assured of a particular "success rate" in achieving good health. Whatever the inherent limits on the benefits that a handicapped patient may derive from inpatient treatment, he is deprived the opportunity to obtain any benefit at all, if, as occurs under Tennessee's policy, he cannot even gain admission to the hospital.

who wish to participate in its program. Thus in the government's view it is irrelevant whether, for example, the state actually incurs no saving, or even wastes money, by requiring a handicapped individual who becomes ill in May to postpone his or her hospitalization until the July; the mere act of treating that patient in a timely fashion is itself "affirmative action." On the interpretation advanced by the Solicitator General the congressional policy mandated by section 504 would be merely one of benign neglect.

Southeastern Community College requires no such extreme result. That decision expressly recognized that there were "instances where a refusal to accommodate the needs of a disabled person amounts to discrimination against the handicapped." 442 U.S. at 413. The claims of the plaintiff in that case were rejected

because she was not an "otherwise qualified" applicant for admission to the school at issue, and could not, even if admitted, "receive even a rough equivalent of the training a nursing program normally gives."442 U.S. 410. Southeastern Community College did not address the issues presented by a case such as this in which the qualifications of the handicapped plaintiffs are not in question.

A construction of section 504 that exempted federal grantees from any duty to take positive measures to make their programs accessible to and effective for the handicapped would clearly be unfaithful to its legislative history. Positive measures are essential to addressing the concerns expressed by Congress in 1973 regarding physical barriers.

> In the context of public transportation and the handicapped, denial of access

> cannot be lessened simply by eliminating discriminatory selection criteria; because the barriers to equal participation are physical rather than abstract, some sort of action must be taken to remove them, if only in the area of new construction or purchasing. "It is not enough to open the door for the handicapped ...; a ramp must be built so the door can be reached." Dopico v. Goldschmidt, 687 F.2d 644, 652 (2d Cir. 1982).

The legislative debates leading to the adoption of section 504 make clear that Congress believed that under certain circumstances the absence of special services or accommodations for the handicapped would constitute discrimination. (See pp. 25-27 supra)

The use of the phrase "affirmative action" in Southeastern Community College has given rise to a certain amount of confusion in the lower courts. Congress used that phrase in sections 501 and 503,

but not in 504, because "affirmative action" is a term of art whose use has traditionally been limited to employment statutes, referring to such personnel measures as recruiting and promoting members of a protected group. The phrase was first utilized in this manner in section 202(1) of Executive Order 11246, issued in 1965. The phrase "affirmative action" is now used in 22 federal statutes[70] to impose positive duties with regard to non-discrimination; in each of these instances the statute involved is concerned with employment practices. Where Congress intended to impose positive duties of other

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70 5 U.S.C. §§ 2302(d), 4313, 4703, 7201(e); 22 U.S.C. § 3905(e); 29 U.S.C. §§721(a), 791(b), 791(d), 793(a), 796(h), 1755, 1781(a), 1781(b), 1781(c); 31 U.S.C. § 732; 38 U.S.C. §§ 2012(a), 2014(c); 42 U.S.C. §§ 2000e-17, 6005; 45 U.S.C. §§ 797b(a), 907, 1004. The phrase is also utilized to describe the obligations imposed on a party guilty of violating the law.

kinds, it has not used the phrase affirmative action. That phrase is not utilized, for example, to describe the special education services required by the Education for the Handicapped Act. 20 U.S.C. §§ 1411 et seq. Similarly, the duty of an employer under Title VII to accommodate the religious needs of an employee is not couched in terms of affirmative action, but is assumed to be encompassed within the duty of non-discrimination. 42 U.S.C. § 2000e(j). Although the respondents in this case seek no remedy which might under any plausible definition be characterized as affirmative action, some clarification of the language in Southeastern Community College may be called for to avoid the confusion which now exists regarding the scope of section 504.

The Solicitor General suggests that HHS has concluded that the 14 day rule at issue in this case does not violate the section 504 regulations. The government's brief states at p. 20:

> Here the district court found that the state plan would fully serve 95% of even handicapped Medicaid eligibles ... For that reason the Health Care Financing Administration has approved Tennessee's 14-day limit. (Emphasis added).

Later, noting that determining whether the regulations have been violated is a responsibility of HHS, the Solicitor asserts, "As we have already made clear, the concerned agency has found no such problem here." (U.S. Br. 29 n.37). The clear implication of these passages is that HHS has held that the 14 day rule is consistent with section 504. The truth is otherwise.

The submission made by Tennessee to HCFA sought and obtained only a decision that the 14 day rule did not violate the Medicaid Act. The submission contained no information whatever regarding the effect of that rule on the disabled. Although exclusive responsibility for resolving section 504 issues is vested in the HHS Office of Civil Rights, no submission was ever made to OCR, and only HCFA officials gave approval to the change. HCFA officials signified their approval merely by signing a form submitted by Tennessee; that approval contains no reference to section 504, to the section 504 regulations, or to any of the facts of this case. Counsel for respondents did file an administrative complaint seeking a decision from the HHS Office of Civil Rights as to whether the 14 day rule violated section 504 and the applicable regulations. That complaint

was filed in August, 1980. (See J.A. 146) To this day, some four years later, OCR has failed to issue a decision resolving that complaint.

CONCLUSION

Since the plaintiffs in this case have carried their initial burden of establishing that Tennessee's method of administration has a disparate adverse effect on the handicapped, the state must justify its choice by demonstrating that the particular budget reduction method selected for limiting Medicaid benefits has a "manifest relationship" to a legitimate interest. Connecticut v. Teal, 457 U.S. 440, 447 (1982); Pet. App. A16. If, as seems unlikely on the present record, the state has such a justification, the admitted adverse impact of its actions at least

compels it to demonstrate that justification. City of Los Angeles Department of Water v. Manhart, 435 U.S. 702, 717 n.31 (1978).

To demand such justification is to do no more than to compel the state to honor the commitments which it has made over the years as a condition of receipt of more than a billion dollars in federal Medicaid funds. Having freely acknowledged the adverse disparate impact of their actions upon the handicapped, and their failure to consider such effects, the defendants must now do what Section 504 has always compelled them to do: they must consider whether their "method of administration of the [inpatient hospital service] .. [has] the ... effect of defeating or substantially impairing accomplishment of the objectives of that program with respect to handicapped persons." 45 C.F.R. § 84

.4(b)(4). Since, as the defendants themselves have always known, the particular method of administration which they chose has such an effect, consideration necessarily must be given to the availability of alternative methods which would be devoid of such discriminatory consequences.

The petitioners' objections to the court of appeals' decision amount in the final analysis to an assertion that the methods by which they administer hundreds of millions of federal Medicaid dollars each year are simply immune from scrutiny under section 504. This is so, argues the state, regardless of the extent to which handicapped patients are forced, in the petitioners' own words, to "suffer proportionally more" under the particular methods of administration selected by the state. In the instant case, the decision whether

or how to cut inpatient coverage was, to the petitioners, purely a mechanical process, involving only a simple mathematical calculation, and no more. (J.A. 68, 96). The petitioners not only admit, they vigorously insist that consideration of the effects of those calculations upon the health and safety of thousands of handicapped patients was entirely extraneous to their administration of the program.

The state's adamant indifference to the plight of the handicapped finds support in neither the legislative history of section 504 nor the regulations implementing that statute. If section 504 is not read, as the sixth circuit read it, to at least require consideration of the needs of the handicapped, congressional intent to deal "comprehensively" with discrimintion against the handicapped in federally

assisted programs will have been frustrated. It is difficult to imagine how section 504 could require any less in these circumstances and still have any practical meaning.

For the above reasons the decision of the court of appeals should be affirmed.

Respectfully submitted,

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No. 83-727

IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

LAMAR ALEXANDER, Governor of the State of Tennessee, Et Al.,
Petitioners,

vs.

HERSHEL CHOATE, Et Al.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

REPLY BRIEF OF THE PETITIONERS, LAMAR ALEXANDER, GOVERNOR OF THE STATE OF TENNESSEE, ET AL.

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On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

REPLY BRIEF OF THE PETITIONERS, LAMAR ALEXANDER, GOVERNOR OF THE STATE OF TENNESSEE, ET AL.

This case involves the legality of a decision by the Tennessee Medicaid Program to reduce the number of inpatient hospital days the Program provides in a fiscal year to each eligible recipient from 20 to 14. At issue is whether or not this reduction violates § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (hereinafter § 504), and regulations promulgated thereunder. The District Court found no violation of § 504 in that both the handicapped and nonhandicapped were extended the same number of inpatient hospital days. The Court of Appeals, however, reversed the District Court and found a *prima facie* violation of § 504 because, at the 14-day limit, a greater percentage of the nonhandicapped than the handicapped would have all their hospital needs satisfied.

Two issues are presented to the Court in this appeal. First, does § 504 prohibit "intentional" discrimination only or does it also prohibit unintentional activities with a discriminatory "effect". Second, if discriminatory effects are prohibited, did the Court of Appeals properly apply the standard in finding a *prima facie* violation of § 504.

I. THE THRESHOLD ISSUE IN THIS CASE, WHETHER § 504 PROHIBITS DISCRIMINATORY EFFECTS, HAS *NOT* BEEN CONCEDED BY THE PETITIONERS AND IS PROPERLY BEFORE THE COURT.

The Respondents contend that in the District Court and the Court of Appeals, the Petitioners "conceded that § 504 applied to practices with a discriminatory effect. . .." (Respondents' Brief, pp. 2, 3). A review of the record reveals no such concession and otherwise supports the propriety of the Court addressing the important and fundamental questions raised by the Petitioners regarding the nature of the discrimination prohibited by § 504.

In the District Court, the Petitioners' position was clearly articulated. It contained no concession as to the application of an effects standard. The Petitioners simply argued that as long as the Tennessee Medicaid Program extended the same number of inpatient hospital days to the handicapped as to the nonhandicapped, it was not in violation of § 504.[1] The District Court

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[1] The Pre-Trial Order in the District Court contained a summary of the Petitioners' defense to the allegation that § 504 had been violated. It provided:

> If Plaintiffs' interpretation of federal laws and regulations regarding discrimination of handicapped individuals, as applied to the proposed reductions, is carried to its logical conclusion then the only limit the program will be allowed to place on services would be at a level providing all of the medical needs of the handicapped. As long as the Tennessee Medicaid Program makes available to handicapped individuals, the same services it

agreed and ruled in the Petitioners' favor. Though the District Court's opinion stated that a disparate impacts test was an appropriate standard under § 504, it declined to apply the test as being unnecessary to decide the case. The District Court ruled that the alleged disparity between the handicapped and nonhandicapped did not amount to discrimination under § 504.

In the Court of Appeals, the Petitioners reiterated the position established in the District Court.[2] Likewise, the Petitioners made no concession that § 504 prohibited discriminatory effects.[3] The Court of Appeals rejected Petitioners argument and reversed the District Court. It based its decision on the failure of the trial court to make a proper inquiry into the "discriminatory effects" of the 14-day limitation. The Court

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> makes available to nonhandicapped individuals, it is in compliance with all federal laws and regulations regarding discrimination against the handicapped. The Tennessee Medicaid Program fully complies with this requirement. (Pre-Trial Order, Theory of the Defendants, p. 3).

The post-trial Proposed Findings of Facts and Conclusions of Law of the Petitioners urged the Court in similar language to find that no violation of § 504 existed. (Proposed Findings of Facts and Conclusions of Law, p. 7, ¶ 13.

[2]Brief of Appellees, pp. 9-14.

[3]The Respondents point to only one portion of the record in support of their assertion that the Petitioners "conceded" this issue. At page 12 of the Brief of the Appellees in the Court of Appeals, the following appears:

> The statistics and studies were computed and analyzed by the parties in several different ways during the course of the trial. Suffice it to say, the studies indicated that the handicapped population of Medicaid recipients would suffer proportionally more from the reduction in hospital benefits than the nonhandicapped Medicaid recipients.

From this language, which does nothing more than summarize various studies, the Respondents glean a major concession on a broad egal question.

then applied its own disparate impact analysis and found a *prima facie* violation of § 504. This was the first time in the progression of the case that a discriminatory effects standard and its related disparate impacts analysis became at issue. The Petitioners, therefore, properly seek review in this Court of the Court of Appeals' use of a discriminatory effects standard to determine a violation of § 504.

II. THE RESPONDENTS' RELIANCE ON THE ADMINISTRATIVE INTERPRETATION AND SUBSEQUENT LEGISLATIVE HISTORY OF § 504 AS EVIDENCE OF CONGRESSIONAL INTENT TO PROHIBIT DISCRIMINATORY EFFECTS IS MISPLACED.

The Respondents' cite as evidence of Congressional intent to prohibit "discriminatory effects", the regulations promulgated in 1976 by the Secretary of Health, Education and Welfare implementing § 504. (Respondents' Brief, pp. 35-37). This Court, however, has been reluctant to give "deference" to these regulations in interpreting § 504.[4] *Southeastern Community College v. Davis,* 442 U.S. 407, 412 n. 11 (1979). Likewise, Congressional activity subsequent to the enactment of § 504, relied upon by the Respondents, is of little help in this case. (Respondents' Brief, pp. 41-46). It simply does not address the issues now before the Court.

The Petitioners have also reviewed Respondents' numerous references to the legislative history surrounding the enactment of § 504. (Respondents' Brief, pp. 15-35). The Petitioners adhere to the position taken in their initial brief that this legislative history is silent as to the precise nature of the discrimination prohibited by § 504. (Petitioners' Brief, p. 15 n. 18).

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[4]The Respondents should not confuse the regulations under consideration in this case with the regulations the Court relied upon in *Consolidated Rail Corp. v. Darrone,* No. 82-862, February 28, 1984, to answer an unrelated question of congressional intent under § 504.

III. THE ISSUES PRESENTED IN THIS APPEAL ARE UNAFFECTED BY CHANGES IN THE TENNESSEE MEDICAID PROGRAM SUBSEQUENT TO TRIAL IN THE DISTRICT COURT AND DO NOT WARRANT A REMAND AS SUGGESTED BY THE RESPONDENTS.

The Respondents contend that two changes in the Tennessee Medicaid Program, subsequent to trial in the District Court, "may" have "aggravated, mitigated, eliminated, or altered" the "adverse impact" upon the handicapped. (Respondents' Brief, p. 63). The Respondents suggest that the case be remanded to the District Court for further evidentiary proceedings. The suggested remand is unwarranted for several distinct and compelling reasons.

First, the changes in the Tennessee Medicaid Program cited by the Respondents have had a de minimus impact upon program recipients and services. For instance, the first change simply restores the former 20-day inpatient hospital level to a very limited group of persons under 21 years of age.[5] These are individuals who receive special diagnostic screening through the Early and Periodic Screening, Diagnosis and Treatment

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[5]A copy of the Tennessee Medicaid Program regulation describing this change is set forth in the Appendix to this Brief at A-1. A somewhat different description of this change is set forth in the Solicitor General's Brief, pp. 5a-9a, in a Notice of Approvai from the Secretary of Health and Human Services. It is apparent that subsequent to the Secretary's approval, the Tennessee Medicaid Program actually implemented the change in a broader scope than originally planned.

(EPSD&T) component of the Medicaid Program.[6] This change impacts only a handful of recipients.[7]

Likewise, the second change cited by the Respondents had only a minimal effect on the Program. The Respondents are greatly mistaken in their assessment of this change. They claim that it "exclude[d] entirely from [the] program a substantial number of individuals who were covered by Medicaid in 1980". (Respondent' Brief, p. 62). Quite to the contrary, this change in 1982 merely "reclassified", not "eliminated", most of one broad group of Medicaid eligibles (medically needy) into another broad classification (categorically needy). In this reclassification process, there was only a small subcategory of individuals who lost eligibility for benefits.[8]

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[6]As a condition of receiving federal financial participation, a state Medicaid Program must provide Early and Periodic Screening, Diagnosis, and Treatment (EPSD&T) to eligible recipients under 21 years of age. 42 U.S.C. § 1396a(a)(4) and 42 C.F.R. § 441.50 *et seq.* Unlike other Medicaid services which are utilized to alleviate a perceived illness or other malady, EPSD&T is aimed at early diagnosis and treatment of conditions in apparently healthy children and youth. The Program also includes dental screening. EPSD&T screening is available to all Medicaid recipients under 21 and they are encouraged to participate. 42 C.F.R. § 441.75.

[7]Though precise figures on the number of individuals under 21 who would be affected by this change are unavailable, it would appear to be modest. According to reports filed by the Tennessee Medicaid Program with the Secretary of Health and Human Services, Tennessee screened 4,960 individuals during the month of June, 1984. *See* Appendix to this Brief, A-2. These screenings resulted in detection of 2,086 medical problems, of which 1,223 were dental related. Of the remaining 863, the increase in hospital days would affect *only those individuals whose condition required hospitalization, if at all, in excess of 14 days.*

[8]Though the change did, in fact, eliminate most "categories" of eligibility under the broad heading of the "medically needy" category, it eliminated very few of the "recipients" who made up the category.

More important than the de minimus nature of these changes is their irrelevance to the issues in this case. No doubt these changes may slightly alter the statistical data relied upon by the Courts below. Accordingly, the precise numerical ratio of handicapped to nonhandicapped who will have all of their inpatient needs met at the 14-day level may be slightly different today than calculated by the District Court in 1981. The issue before this Court, however, is not the "current" accuracy of this statistical ratio. The issue is whether that ratio and the analytical process which produced it is at all relevant to an inquiry under § 504. Specifically, does § 504 prohibit discriminatory effects and, if so, did the Court of Appeals apply a proper standard to ascertain such effects? A remand to the District Court will in no way aid this Court in resolving these issues. It may, however, be seen as a tacit approval of the standard adopted by the Court of Appeals.

Finally, a remand to the District Court could prevent the unsettled issues in this case from ever reaching this Court. Since the Tennessee Medicaid Program is not a static entity, but a large, complex and continually changing social welfare program, it will always be subject to the types of changes the Respondents argue requires a remand. If the Respondents have their way, the Tennessee Medicaid Program will have to be frozen at some specific point in time to preserve the ripeness of the important issues now before the Court.

Virtually all of them were shifted into newly-created classifications under the other large classification of "categorically needy". A Tennessee Department of Human Services' Bulletin describing the change is attached hereto as Appendix A-3. As noted in the very first paragraph, the only individuals whose "*eligibility will be eliminated have been eligible for only restricted services through the Medicaid Program since July 1, 1981.*" (Emphasis supplied). These persons were not counted in the statistical data used by the District Court in 1981. The Bulletin also contains good examples of the "reclassification" of individuals whose category was eliminated. *See, e.g.*, ¶ A.1. of the Bulletin.

CONCLUSION

For the reasons set forth above, and in their initial Brief, the Petitioners respectfully request that the decision of the Sixth Circuit Court of Appeals be reversed.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing Reply Brief of the Petitioners, Lamar Alexander, Governor of the State of Tennessee, et al., has been forwarded to the below-listed counsel, on this the 21st day of September, 1984.

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APPENDIX

APPENDIX

RULES OF

Tennessee Department of Health And Environment

Division of Medicaid

GENERAL RULES

CHAPTER 1200-13-1

Rule 1200-13-1-.03 (AMOUNT, DURATION AND SCOPE OF ASSISTANCE) (1)(e) is amended by adding a sentence to this subpart. The amended rule shall read as follows:

(e) Early periodic screening and diagnosis of individuals under 21 years of age and treatment of conditions found will be covered for eligible recipients. Those individuals receiving EPSDT services shall be allowed up to twenty days of inpatient hospital services and twenty physician inpatient hospital visits per fiscal year.

Statutory Authority: T.C.A. 14-23-105, and T.C.A. 14-23-109

Rule 1200-13-1-.03 (AMOUNT, DURATION AND SCOPE OF ASSISTANCE) (1)(a) is amended by adding the words, "except as set out in Rule 1200-13-1-.03(1)(e)" at the end of the first sentence so that the rule reads as follows:

(a) In-Patient hospital services other than those provided in an institution for mental disease or tuberculosis will be limited to fourteen days per fiscal year, except as set out in Rule 1200-13-1-.03(1)(e). Any hospital days paid by insurance or other third party benefits will be considered to be days paid by the Medicaid program. Friday and Saturday admissions will be limited to emergencies or surgery the same or next day.

Statutory Authority: T.C.A. 14-23-105, and T.C.A. 14-23-109

FORM SRS-NCSS-120

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service
National Center for Social Statistics

OMB No. 83-R0295 -
Approval expires 7/31/75

MONTHLY STATISTICAL REPORT ON MEDICAL CARE
PART III
Number of Individuals Receiving Early and Periodic Screening Services and Payments for such Services

State Tennessee Report for month of June, 1984

Item	Age of children screened		
	Total (1)	Under age 6 (2)	Age 6-20 (3)
1. Number of individuals screened during month *(sum of 2 and 3)*	4,964	3,683	1,281
2. Number with no referrable conditions uncovered or suspected during screening	1,679	803	876
3. Number with referrable conditions uncovered or suspected during screening *(sum of 3a and 3b)*	3,285	2,880	405
a. Referred during month for diagnosis and/or treatment	2,996	2,671	325
b. Not referred	289	209	80
4. Number of individuals screened with:			
a. Visual problems	374	93	281
b. Hearing problems	122	82	40
c. Dental problems	1,223	512	711
d. Lead poisoning	4	2	2
e. Other problems	363	226	137
5. Total payments for screening services	$ 158,868	$ 114,559	$ 44,309

— A-2 —

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STATE OF TENNESSEE
DEPARTMENT OF HUMAN SERVICES
NASHVILLE

MAY 17, 1982

BULLETIN NO. 65
MN-82-13
FA-82-29
SS-82-19

To: Regional, County, and Area Offices

From: Sammie Lynn Puett, Commissioner

Subject: Medicaid Eligibility Changes

Effective July 1, 1982, the Department of Human Services, in cooperation with the Department of Public Health, intends to implement cost containment measures in the Medicaid program which will eliminate eligibility for certain persons classified as Medically Needy. Individuals whose eligibility will be eliminated have been eligible for only restricted services through the Medicaid program since July 1, 1981. As of July 1, 1982, all individuals determined eligible for Medicaid on or after July 1, 1982, will receive a non-restricted Medicaid card which will provide them with the full range of Medicaid services provided in Tennessee.

As of July 1, 1982, several coverage groups and categories of eligibility will be added. This bulletin is being issued to alert staff to the proposed changes and allow supervisors to begin to plan for the desk reviews that will be required prior to implementation. Specific instructions regarding desk reviews will be issued by June 1.

A. *Ineligible Coverage Groups*

The proposed changes include termination of Medicaid coverage for the following groups of individuals under the Medically Needy program:

1. **Medically Needy Aged, Blind, and Disabled**

   Non-institutionalized aged, blind, and disabled individuals will no longer qualify for Medicaid in Tennessee unless they are eligible for SSI. Arrangements are being made to cover any aged, blind, or disabled individuals that are institutionalized in long-term care facilities as categorically needy under a special eligibility category.

2. **Caretaker Relatives and Second Parents of AFDC-MN Children**

   Parents and caretaker relatives of AFDC-MN children will no longer be eligible for Medicaid coverage in their own right unless they qualify for AFDC or SSI or are pregnant (see B-2-a). AFDC-MN children will continue to be covered.

3. **Eligible Coverage Groups**

   1. **Categorically Needy**

      The current Categorically Needy coverage groups will be retained. In addition, the following new coverage groups will be added to this category:

      a. Individuals in long-term care with income less than 300% of the SSI Federal Benefit Rate for an individual living in his/her own home.

      b. Individuals in long-term care who would be eligible for AFDC or SSI except for their institutional status.

      c. Children 18 to 21 with special diagnoses. (These diagnoses are yet to be defined in their entirety.)

      d. Children under 21 who are deprived of parental support and would qualify for AFDC except for age.

e. Unborn children who meet the financial requirements for AFDC and would eligible for AFDC *if* born and *if* deprived of parental support. This includes coverage of unborn children in intact families in which deprivation of parental support is not a factor. Prenatal care will be available to unborn children who are needy by AFDC standards but are not deprived.

2. **Medically Needy**

Under the Medically Needy program, the full range of services will be provided to the following new groups:

a. AFDC-MN children *only,* including unborns, as the adult caretaker is no longer eligible *except* for the pregnant woman who, but for income and resources, would be eligible as Categorically Needy and who meet the Medically Needy financial requirements.

b. Children with special diagnoses.

The Medically Needy program will continue to extend benefits to other eligible groups of children under 21 as it has heretofore. These include children in foster care, subsidized adoption, psychiatric hospitals and other special living arrangements.

While it is anticipated that the above changes will not be effective until July 1, certain modifications to the eligibility process must be implemented now to ensure an orderly transition. It is important that the eligibility period on Medicaid approvals processed under the spend-down provision *NOT* extend beyond June 30, 1982. This will result in some eligibles receiving coverage for only one or two months depending on application date. As new applications are processed, applicants should be advised of the time limitation.

It will be necessary for county offices to continue accepting applications through September, 1982, on Medically Needy adults requesting retroactive Medicaid coverage. Eligibility on such applications can be determined only through June, 1982.

It is also anticipated that all non-institutionalized adult Medically Needy cases currently active for Medicaid will be closed effective July 1, 1982, with the recipients being given 10 days advance notice of adverse action.

All parents and caretaker relatives currently in AFDC-MN cases will be removed effective July 1, 1982, except for those parents who are known to be pregnant at the time of the anticipated removal. AFDC-MN income and resource policies are presently being re-written tro match AFDC policy, and all AFDC-MN exceptionally eligible cases must be reviewed in June in light of those new requirements. Further details on the processing of these actions are forthcoming.

A desk review will also be necessary to convert the institutionalized Medically Needy cases to the special categorical eligibility category by July 1, 1982. It is anticipated that Systems can provide assistance with that desk review and that it will be done in conjunction with the annual SSA desk review.

Please direct any questions regarding these anticipated changes to the Medical Assistance Policy Unit.

SLP:AMW:rw